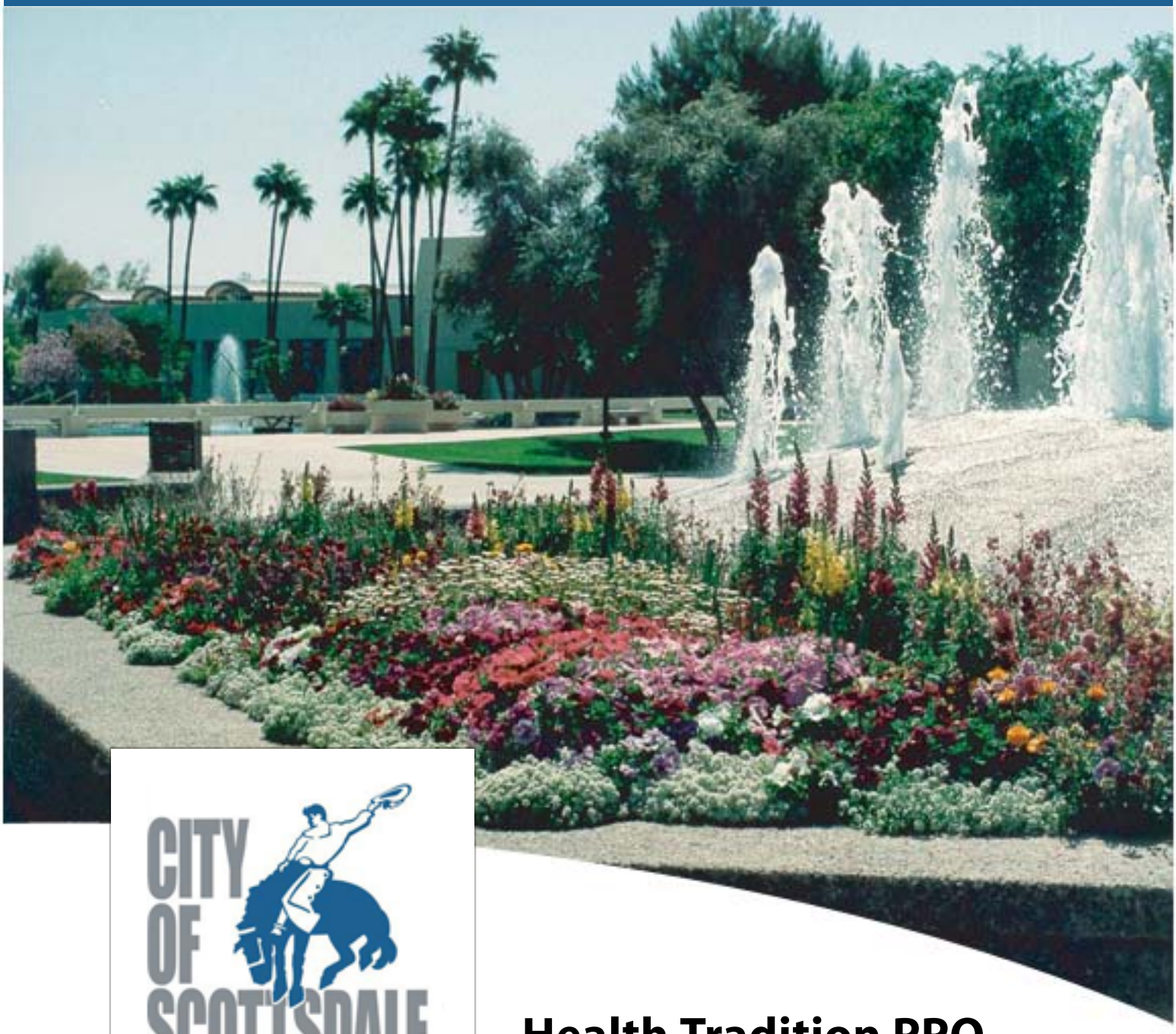
City of Scottsdale
Summary Plan Description



Health Tradition PPO
Medical Benefit Plan

Effective July 1, 2006

Summary Plan Description

For the

City of Scottsdale

Health Tradition PPO

Medical Benefit Plan

Effective July 1, 2006

Administered by:

MMSI

A Mayo Health Company

INTRODUCTION

City of Scottsdale, the Employer, has established the City of Scottsdale Health Tradition PPO Medical Benefit Plan (Plan) in order to provide comprehensive healthcare benefits for the Employer's Eligible Employees and their Dependents. The Plan described in this document is effective July 1, 2006, except for those provisions that specifically indicate other effective dates, and replaces all other plan documents previously provided to you.

The medical benefits of the Plan are self-funded with contributions from the City and Eligible Employees and Retirees. An independent Claims Administrator processes claims and performs other administrative duties.

This Plan is a group health plan for purposes of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and shall be administered in a manner consistent with HIPAA. Capitalized words in this Plan are defined in the *Definitions* section.

It is very important to review this Summary Plan Description (SPD) carefully to confirm a complete understanding of the benefits available, as well as responsibilities, under the Plan. The SPD should be read in its entirety because many of its provisions are interrelated. Under the Plan, Members may receive different levels of benefits depending on where Covered Services are received and depending upon whether Prior Authorization, if required, was obtained.

Generally, when care is received at an In-Network Healthcare Provider, the Member will receive the highest level of benefits at the lowest cost. When care is received from an Out-of-Network Healthcare Provider, benefits will be reduced. Prior Authorization, if required, is the Member's responsibility

The Employer has contracted with an independent Claims Administrator to perform certain consultative and management services related to this Plan. The Employer retains ultimate authority for the Plan. MMSI, Inc. (MMSI) is the Claims Administrator and will process claims, manage the Plan network and answer medical benefit and claim questions. MMSI will be referred to as the Claims Administrator throughout this SPD.

The MMSI Claims Administrator's customer service representatives are available to answer any questions or concerns regarding the Plan. Phone lines are open from 7 a.m. to 7 p.m. Central Time Monday through Friday (excluding holidays). For enrollment or eligibility questions, please contact the Benefits Department of your Employer.

QUESTIONS	
MMSI Customer Service (toll-free)	1-866-206-5724
MMSI Customer Service (TDD for hearing impaired)	1-800-407-2442
City of Scottsdale (employer)	1-480-312-7600

This Plan is not subject to the Employee Retirement Income Security Act of 1974 (ERISA).

PLAN ADMINISTRATIVE INFORMATION

Employer:

City of Scottsdale
Human Resources Department
7575 E. Main Street
Scottsdale, AZ 85251

Claims Administrator:

MMSI, Inc. (MMSI)
5777 East Mayo Boulevard
Phoenix, AZ 85054
1-866-465-5148

Please Note: MMSI performs claims processing services pursuant to a contract; it does not insure benefits under the Plan.

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SECTION I

DEFINITIONS

This Section defines the terms used in this Plan. These terms will be capitalized throughout this Plan when referred to in the context defined. There may be other terms defined in specific sections of this Plan.

1.1 **Allowed Charge** - the maximum dollar amount eligible for payment for a procedure or service as determined by the Plan. This includes billed charges, contracted amounts or Usual and Customary Rates, depending on the Healthcare Provider's relationship with the Plan and/or the Healthcare Services provided.

1.2 **Ambulance** - a specially designed or equipped vehicle used only for transporting the critically ill or injured to a healthcare facility. The ambulance service must meet state and local requirements for providing transportation of the sick or injured and must be operated by qualified personnel who are trained in the application of basic life support.

1.3 **Claims Administrator** - The Claims Administrator is a third party retained by the Employer. The Claims Administrator's responsibilities typically consist of initially determining the validity of claims and administering benefit payments under this Plan. The actual responsibilities of the Claims Administrator are described in the contract between the Employer and the Claims Administrator. The Claims Administrator is MMSI, Inc. (MMSI).

1.4 **COBRA** - Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time as it applies to public sector entities through the Public Health Services Act.

1.5 **Code** - Internal Revenue Code of 1986, as amended from time to time.

1.6 **Cost Sharing Amounts** - the dollar amount a plan participant is responsible for paying when Covered Services are received from a Healthcare Provider. Cost Sharing Amounts include Coinsurance, Copayment, and Deductible amounts. Applicable Cost Sharing Amounts are identified in the *Schedule of Benefits* section. Healthcare Providers may bill a plan participant directly or request payment of Cost Sharing Amounts at the time Covered Services are provided.

(a) **Coinsurance** - the charge a Member must pay for certain Covered Services after any applicable Deductibles and Copayments have been paid and until the Annual Out-of-Pocket Maximum has been reached. Covered Services subject to Coinsurance and the amounts are listed in the *Schedule of Benefits* section. Coinsurance is a percentage of the Allowed Charge. In some instances, the Member will be responsible at the time and place of service to pay any Coinsurance directly to the Healthcare Provider. In other instances, the Healthcare Provider will bill the Member. These arrangements are between the Member and the Healthcare Provider.

(b) **Copayment** - the charge a Member must pay for certain Covered Services. Covered Services subject to a Copayment and the amounts are listed in the *Schedule of Benefits* section. A Copayment is a flat dollar amount. In some instances, the Member will be responsible at the time and place of service to pay any Copayment directly to the

Healthcare Provider. In other instances, the Healthcare Provider will bill the Member. These arrangements are between the Member and the Healthcare Provider.

(b) **Deductible** - the aggregate amount for certain Covered Services that is a Member's responsibility each Coverage Year before the Plan will begin to pay for Covered Services. There are separate In-Network and Out-of-Network Deductibles that apply.

(c) **Annual Out-of-Pocket Maximum for Medical Expenses** - the total Deductible, Copayment, and Coinsurance amounts for certain Covered Services (not including Retail or Mail Order Prescription Drugs) that are a Member's responsibility during a Coverage Year. The following amounts are *not* considered or taken into account to accumulate to the out-of-pocket maximum: charges that are not Covered Services under the Plan (e.g., charges which exceed Usual and Customary Rates and costs paid by the Member as a result of the Member's failure to comply with Prior Authorization requirements), charges in excess of Plan maximums, Retail and Mail Order Prescription Drug expenses and mental health/substance abuse copays. When the Annual Out-of-Pocket Maximum for Medical Expenses is met, this Plan will pay 100% of the Allowed Charge for Covered Services (except Retail and Mail Order Prescription Drugs and mental health/substance abuse) incurred during the remainder of the Coverage Year. The Annual Out-of-Pocket Maximum for Medical Expenses renews on the Plan anniversary of each consecutive Coverage Year.

1.7 **Confinement** - a continuous stay in the Hospital(s) or extended care facility(ies) or other health care facility or combination thereof, due to an Illness or Injury diagnosed by a Physician, which lasts at least one day and one night.

1.8 **Continued Care** – certain specified hours of service per day provided by a Registered Nurse, Licensed Practical Nurse, or Home Health Care aide, during a period of Skilled Care needed in order to maintain an ill Member at home.

1.9 **Cosmetic Surgery or Treatment** - Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic Surgery or Treatment includes, but is not limited to, removal of tattoos, breast augmentation, or other medical, dental or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee

1.10 **Coverage Year** - the time period from July 1, through June 30th. The coverage year is commonly referred to as the Plan Year.

1.11 **Covered Service** - Healthcare Services described in the *Schedule of Benefits* section for which Plan benefits will be provided, unless limited or excluded in the *Exclusions* section of this Plan. A Covered Service is incurred on the date the Healthcare Service is received.

1.12 **Creditable Coverage** - defined by HIPAA and generally means coverage without a lapse of more than sixty-three (63) days for each Member. Creditable Coverage is healthcare coverage provided under:

(a) a health benefit plan (without regard to whether it was issued to a small employer and including blanket accident and sickness insurance); or

(b) part A or part B of Medicare; or Medicaid

(c) medical assistance; or

(d) general assistance medical care; or

(e) a state high risk pool; or

(f) a self-insured health plan; or

(g) the Civilian Health and Medical Program of the Uniformed Services ("TRICARE" f/n/a CHAMPUS) or other coverage provided under United State Code, title 10, chapter 55; or

(h) a healthcare network cooperative or by a health provider cooperative under state law; or

(i) a medical care program of the Indian Health Service or of a tribunal organization; or

(j) the Federal Employees Health Benefits Plan, or other coverage provided under United States Code, title 5, chapter 89; or

(k) a health benefits plan under section 5(e) of the Peace Corps Act, United States Code, title 22, section 2504(e); or

(l) State Children's Health Insurance Program (SCHIP), foreign plans, US government plans;

(m) a plan similar to any of the above plans provided in this state or another state, or as required by law.

1.13 **Custodial Care** - a type of care designed to assist an individual to meet the activities of daily living. It includes assistance in walking, getting in and out of bed, bathing, dressing, preparation of meals (Including special diets), supervision of medication that can be self-administered and care that does not require the continuing attention of licensed medical personnel. Custodial Care also includes rest cures and home care provided by family members.

1.14 **Dependent**- a dependent of the Subscriber who qualifies for membership under this Plan in accordance with the requirements specified below:

(a) a Spouse (see the definition of spouse later in this chapter)

(b) the Subscriber's unmarried child under the age of 19, or under the age of 25, if enrolled in some part of five calendar months of the tax year for the number of hours or courses required to be considered full time attendance as defined by the qualified educational organization.

The term child includes:

(1) A natural child.

(2) A stepchild.

(3) A legally adopted child.

(4) A child placed for adoption with the Subscriber. For purposes of this definition, placement for adoption means a child who has been placed for adoption with the Subscriber and for whom the application and approval procedures for adoption pursuant to AZ Statutes Section 8-105 or 8-108 have been completed.

(5) A child for whom the Subscriber or the Spouse has been appointed legal guardian.

(c) Dependents for whom the Subscriber has a Medical Support Order.

(d) The Subscriber's unmarried handicapped child over age 19 who is and continues to be:

(1) incapable of self-support because of mental retardation or physical handicap;

(2) became so incapacitated prior to the limiting age; and

(3) is chiefly dependent upon the Subscriber for support and maintenance.

Proof of such incapacity and dependency must be furnished to the Plan within thirty-one (31) days of the child's attainment of the limiting age. Coverage will be continued as long as the child continues to be incapacitated and dependent, unless otherwise terminated in accordance with the terms of this Plan. Before granting this extension, the Plan may reasonably require that a Physician designated by the Plan examine the child at the Plan's expense. The Plan may require at reasonable intervals thereafter satisfactory proof of the child's continued incapacity and dependency, Including medical examinations at the Plan's expense. However, such proof will not be required more than once a year following the two (2) year period after the child reaches the limiting age.

(e) A domestic partner means an individual of either sex who shares a long-term committed relationship of indefinite duration with a benefit eligible employee. A Domestic Partnership Affidavit must be completed and submitted to the Plan with at least three (3) items of documentation as evidence of joint responsibility and commitment and that documentation must be pre-dated by twelve (12) months. Benefits are provided post-tax for the Domestic Partner.

(f) A child of a Domestic Partner who does not qualify as a child of the employee/retiree may be eligible under this plan however benefits will be post-tax for an eligible child of the Domestic Partner.

(g) Individuals specifically excluded from the definition of a Dependent are:

(1) any person on active military duty;

(2) any person covered under this Plan as a Subscriber.

1.15 **Disposable Supplies** - Goods or supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including, but not limited to, bandages, hypodermic syringes, diapers, soap or cleansing solutions, etc. Certain disposable supplies may be covered by the Plan.

1.16 **Durable Medical Equipment** - standard model medical equipment and/or supplies, which are Medically Necessary, prescribed by a Healthcare Provider for a specific therapeutic purpose in treating an Illness or Injury, and designed to be used repeatedly, generally over extended periods of time.

1.17 **Educational** - the primary purpose of a service or supply is to provide the Member with any of the following: training in the activities of daily living, instructions in scholastic skills such as reading and writing, preparation for an occupation or treatment for learning disabilities.

1.18 **Eligible Employee** - an Employee who meets the eligibility criteria for the Plan as described in the *Eligibility and Participation* section and who has not ceased to meet the eligibility criteria.

1.19 **Emergency** - any condition requiring care which, in the judgment of a reasonable person, is immediately necessary to preserve life, prevent serious impairment to bodily functions, organs, or parts, or to prevent placing the physical or mental health of the Member in serious jeopardy.

1.20 **Emergency Ambulance Service** - services provided by an Ambulance service authorized to operate following the onset of a medical condition that manifests itself by symptoms of pain, Illness or Injury that the absence of accessing an Ambulance or emergency response by calling 911 or a designated telephone number to reach a public safety answering point and receiving time sensitive medical attention could reasonably be expected to result in any of the following:

- Serious jeopardy to the Member's health;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part.

1.21 **Emergency Services**- Healthcare Services that are provided to a Member in a licensed Hospital emergency facility by a Healthcare Provider after the recent onset of a medical condition that manifests itself by symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Serious jeopardy to the Member's health;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part.

This includes unforeseen conditions requiring hospitalization or medical services necessary for the treatment of accidental Injury, relief of acute pain, initial treatment of acute infection, or the amelioration of Illness.

1.22 **Employee** - any person employed by the Employer, except it shall not include a self-employed individual as described in Section 401(c) of the Code. Employee does not include the following:

(a) Any Employee included within a unit of Employees covered by a collective bargaining unit unless such agreement expressly provides for coverage of the Employee under this Plan;

(b) Any Employee who is a nonresident alien and receives no earned income from the Employer from sources within the United States; and

(c) Any Employee who is a leased Employee as defined in Section 414(n)(2) of the Code.

(d) any individual who performs services for the Employer through, and is paid by, a third-party (including but not limited to an employee leasing or staffing agency) even if such individual is subsequently determined to be a common law employee of the Employer; or

(e) any individual who performs services for the Employer pursuant to a contract or agreement (whether verbal or written) which provides that such individual is an independent contractor or consultant, even if such individual is subsequently determined to be a common law employee of the Employer.

1.23 **Employer** – **City of Scottsdale**, which is an Arizona city, town, or county.

1.24 **Experimental or Investigative** - a drug, device, Healthcare Service or procedure that meets any one or more of the following criteria, as determined by the Plan Administrator or its designee:

(a) The drug, device, Healthcare Service or procedure cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished.

(b) Reliable evidence shows that the drug, device, Healthcare Service or procedure is the subject of ongoing Phase I, II, or III clinical trials. (Phase I clinical trials determine the safe dosages of medication for Phase II trials and define acute effects on normal tissue. Phase II clinical trials determine clinical response in a defined patient population. If significant activity is observed in any disease during Phase II, further clinical trials usually study a comparison of the experimental treatment with the standard treatment in Phase III trials. Phase III trials are typically quite large and require many patients to determine if a treatment improves outcomes in a large population of patients.)

(c) Reliable evidence shows that the drug, device, Healthcare Service or procedure is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis.

(d) Reliable evidence shows that the consensus among experts regarding the drug, device, Healthcare Service or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis.

Notwithstanding the above, the Plan may determine that a drug, device, Healthcare Service or procedure is not Investigative if it shows sufficient promise. In order to show sufficient promise, the Plan must find, on a case-by-case basis, that the drug, device, Healthcare Service or procedure meets the following criteria:

- Reliable evidence preliminarily suggests a high probability of improved outcomes compared to standard treatment (e.g., significantly increased life expectancy or significantly improved function); and
- Reliable evidence suggests conclusively that beneficial effects outweigh any harmful effects; and
- If applicable, the FDA has indicated that the approval of the drug, device, Healthcare Service or procedure for other proposed use is pending and likely to occur in the near future.

Reliable evidence includes only published reports and articles in the authorized medical and scientific literature that delineates the written protocol or protocols used by the treating facility

or by another facility studying substantially the same drug, device, Healthcare Service, or procedure, and that describes among its objectives determinations of safety, efficacy, or efficacy in comparison to conventional alternatives, or toxicity.

1.25 **Family** – a Subscriber and his/her properly enrolled Dependents.

1.26 **FMLA** - the Family and Medical Leave Act of 1993, as amended from time to time.

1.27 **Healthcare Provider** - Institutional Healthcare Providers or Professional Healthcare Providers providing healthcare services to Members. Each Healthcare Provider must be licensed, registered or certified by the appropriate state agency where the healthcare services are performed. Where there is no appropriate state agency, the Healthcare Provider must be registered or certified by the appropriate professional body. Healthcare Provider Includes those listed below:

(a) **Advanced Practice Nurse** - Including a Clinical Nurse Specialist, Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife and Nurse Practitioner.

(b) **Ambulatory Surgical Facility -** a facility with an organized staff of Physicians that:

- has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis; and
- provides treatment by or under the direct supervision of a Physician or other Healthcare Provider; and
- does not provide inpatient accommodations; and
- is not, other than incidentally, a facility used as an office or clinic for the private practice of a Physician or Dentist.

(c) **Chiropractor** - a Doctor of Chiropractic (D.C.).

(d) **Dentist** - a Doctor of Dental Surgery (D.D.S.), Oral Pathologist, Oral Surgeon or Doctor of Dental Medicine (D.M.D.).

(e) **Home Health Agency** - an agency that provides Home Health Care and that is Medicare certified and licensed or approved under state or local law.

(f) **Hospice** - an organization that provides medical, social and psychological services as palliative treatment for Members with a terminal illness and life expectancy of less than six months.

(g) **Hospital** - a licensed institution operated pursuant to law that is engaged in providing inpatient and outpatient diagnostic and therapeutic services for the diagnosis, treatment and care of sick and injured persons by or under the direct supervision of Physicians or other Healthcare Providers.

(h) **Licensed Practical Nurse (L.P.N./LVN)** - A graduate of a school of practical nursing who has passed the practical nursing state board examination and is licensed to administer care, usually working under direction of a licensed physician or a registered nurse.

(i) **Licensed Registered Dietician** - A specialist in dietetics who has met the requirements for certification stipulated by the American Dietetic Association.

(j) **Occupational Therapist** - A professional who has met the requirements to practice in states with licensure laws governing occupational therapy. Usually, licensed therapists have been certified by the National Board for Certification in Occupational Therapy as a registered occupational therapist (OTR). Some state governments, as part of their licensure statutes, permit use of the OTR/L or LOTR designations.

(k) **Optometrist** - a Doctor of Optometry (O.D.).

(l) **Physical Therapist** - A licensed practitioner of physical therapy who has graduated from an accredited physical therapy education program.

(m) **Physician** - a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.).

(n) **Physician Assistant (P.A.)** - an individual licensed by the medical examining board to provide medical care with Physician supervision and direction.

(o) **Podiatrist** - a Doctor of Podiatry (D.P.), Doctor of Surgical Chiropody (D.S.C.), Doctor of Podiatric Medicine (D.P.M.) or Doctor of Surgical Podiatry (D.S.P.).

(p) **Psychologist** - a mental health professional who has a doctoral degree (usually a Ph.D. or a Psy.D.) in clinical, counseling, industrial, or school psychology and has also met state licensing criteria.

(q) **Radiation Therapist** - Radiation therapy technologist.

(r) **Registered Nurse (R.N.)** - A nurse who has graduated from a state-approved school of nursing, has passed the professional nursing state board examination, and has been granted a license to practice within a given state.

(s) **Rehabilitation Facility** - an institution, or a distinct part of an institution providing rehabilitation services and related services to persons on an inpatient basis.

(t) **Respiratory Therapist** – an individual who is qualified through education, training, and experience to provide respiratory therapy services through planned exercises and treatments that help patients recover lung function, such as after surgery.

(u) **Skilled Nursing Facility** - an institution, or a distinct part of an institution providing Skilled Care and related services to persons on an inpatient basis.

(v) **Social Worker** – an individual who is qualified through education, training and experience to provide services in relation to the treatment of emotional disorders, psychiatric conditions or substance abuse when employed by, or under the supervision of, an M.D., D.O., or Ph.D.

(w) **Speech Therapist** – An individual trained to assist patients in restoring speech and communication functions through the use of special techniques for correction of speech and language disorders.

(x) **Urgent Care Facility** - a clinic, acute care facility or walk-in clinic with Urgent Care hours or walk-in clinic hours providing treatment for Urgent Care and properly licensed where licensure is required.

1.28 **Healthcare Services** - the provision of medical treatment, Disposable Supplies, Durable Medical Equipment, Orthotics or Prosthetics and other medically related services as defined in the Plan.

1.29 **HIPAA** - Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

1.30 **Home Health Care** - Skilled Care for the treatment of a Member's Illness or Injury requiring only Intermittent Care.

1.31 **Illness** - any sickness or disorder, including pregnancy and related conditions. The term "Illness" does not include an illness with respect to which benefits are payable under any workers' compensation, occupational disease, or similar law

1.32 **Including or Includes** - including, but not limited to.

1.33 **Injury** - a non-occupational accidental bodily injury caused directly and exclusively by external, violent, and purely accidental means. The term "Injury" does not include an injury with respect to which benefits are payable under any workers' compensation, occupational disease, or similar law.

1.34 **In-Network** - the MMSI network of Healthcare Providers. For the Retail Prescription Drug benefit, In-Network shall mean the SXC Health Solutions Pharmacy Network. For outpatient Mental Health and Chemical Dependency services, In-Network shall mean CIGNA Behavioral Health providers.

1.35 **Institutional Healthcare Provider** - Healthcare Providers Including an Ambulatory Surgical Facility, Home Health Agency, Hospice, Hospital, Skilled Nursing Facility or Urgent Care Facility.

1.36 **Intermittent Care** - up to three (3) times per week (up to twenty-four [24] hours per day), with increased frequency to meet Short-Term transitional care needs.

1.37 **Maximum Lifetime Benefit** - the total dollar amount of Covered Services a Member may receive during a lifetime while enrolled under this Plan. The Maximum Lifetime Benefit is calculated based on a combination of benefits received from In-Network and Out-of-Network Healthcare Providers. The Maximum Lifetime Benefit does not include amounts that are the Member's responsibility or Prescription Drugs. See the *Schedule of Benefits* section.

1.38 **Medically Necessary**:

A. A medical or dental service or supply will be determined to be **"Medically Necessary"** by the Plan Administrator or its designee if it:
   1. is provided by or under the direction of a Physician or other duly licensed Health Care Provider who is authorized to provide or prescribe it or Dentist if a dental service or supply is involved; and
   2. is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted American medical and dental standards; and

3. is determined by the Plan Administrator or its designee to meet all of the following requirements:
   - It is consistent with the symptoms or diagnosis and treatment of an illness or injury; and
   - It is not provided solely for the convenience of the patient, Physician, Dentist, Hospital, Health Care Provider, or health care facility; and
   - It is an **"Appropriate"** service or supply given the patient's circumstances and condition; and
   - It is a **"Cost-Efficient"** supply or level of service that can be safely provided to the patient; and
   - It is safe and effective for the illness or injury for which it is used.

B. A medical or dental service or supply will be considered to be **"Appropriate"** if:
   1. It is a diagnostic procedure that is called for by the health status of the patient, and is as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.
   2. It is care or treatment that is as likely to produce a significant positive outcome as and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.

C. A medical or dental service or supply will be considered to be **"Cost-Efficient"** if it is no more costly than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.

D. The fact that your Physician or Dentist may provide, order, recommend or approve a service or supply does not mean that the service or supply will be considered to be medically necessary for the medical or dental coverage provided by the Plan.

E. A Hospitalization or confinement to a health care facility will not be considered to be medically necessary if the patient's illness or injury could safely and appropriately be diagnosed or treated while not confined.

F. A medical or dental service or supply that can safely and appropriately be furnished in a Physician's or Dentist's office or other less costly facility will not be considered to be medically necessary if it is furnished in a Hospital or health care facility or other more costly facility.

G. The non-availability of a bed in another health care facility, or the non-availability of a Health Care Provider to provide medical services will not result in a determination that continued confinement in a Hospital or other health care facility is medically necessary.

H. A medical or dental service or supply will not be considered to be medically necessary if it does not require the technical skills of a Dental or Health Care Practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any Dental or Health Care Provider, Hospital or health care facility.

1.39 **Medicare** - Title XVIII of the Social Security Act, as amended from time to time.

1.40 **Member** - a Subscriber or Dependent who is participating under the Plan in accordance with the *Eligibility and Participation* section and who has not ceased to be a participant. Member also includes former Subscribers or former Dependents who are otherwise entitled to coverage and properly enrolled under the Plan.

1.41 **Membership Card** - an identification card issued in the Subscriber's name identifying the membership number of the Subscriber.

1.42 **Medical Support Order (MSO)** - a medical support order as described in AZ Statute 20-692.03.

1.43 **Orthotic** - a custom made brace or external device made for a weak, diseased or injured body part. An Orthotic can increase, decrease or eliminate motion or support the weak, diseased or injured body part.

1.44 **Out-of-Network** – Healthcare Providers that are not In-Network. When Members seek Covered Services from Out-of-Network Healthcare Providers, they will generally receive a lower level of benefit payment. In addition to Cost Sharing Amounts, the Member will also be responsible for any charges above Usual and Customary Rates when receiving Covered Services from Out-of-Network Healthcare Providers.

1.45 **Part-Time Care** - means up to three (3) hours of Rehabilitative or terminal care services per day, with increased hours provided to meet Short-Term transitional care needs. Aside from Short-Term transitional care needs, more than three (3) hours per day is considered Continuous Care.

1.46 **Plan** - the City of Scottsdale Health Tradition PPO Medical Benefit Plan for the provision of healthcare benefits to Members, as amended from time to time.

1.47 **Plan Year** - see the definition of Coverage Year.

1.48 **Prescription Drug** - medications and drugs that bear the legend "Federal law prohibits dispensing without a prescription." This term also includes medicines and drugs that contain a legend drug that requires compounding by a pharmacist to the order of a Physician or other authorized Healthcare Provider and are approved by the U.S. Food and Drug Administration (FDA). Insulin and diabetic supplies (e.g., syringes, lancets and testing strips) are generally covered as Prescription Drugs as well. Prescription Drugs include:

(a) **Brand Name Drug** - a patent-protected Prescription Drug.

(b) **Generic Drug** - a Prescription Drug whose patent has expired and is usually manufactured by several pharmaceutical companies. FDA A-rated Generic Drugs (which are the only type of Generic Drugs covered under this Plan) contain the same active ingredient as the Brand Name Drug, are manufactured under the same FDA standards and are considered equivalent in all respects to the Brand Name Drug.

(c) **Formulary** - a list of Prescription Drugs approved by the Plan for use by Members, as amended from time to time

(d) **Injectable Prescription Drug -** a product that meets the definition of a Prescription Drug but is administered by injection. For purposes of this Plan, insulin and sumatriptan (Imitrex) are considered to be Prescription Drugs and not Injectable Prescription Drugs.

(e) **Non-Formulary Drug** - A Prescription Drug that does not appear on the plan-approved Formulary.

1.49 **Preventive Care** - Healthcare Services rendered solely for the purpose of health maintenance and screening for disease and not for the treatment of an Illness or Injury.

1.50 **Prior Authorization** - authorization from the Plan for specific Covered Services before they are rendered, in accordance with the *Utilization Management* section.

1.51 **Professional Healthcare Provider** - Healthcare Providers including an Advanced Practice Registered Nurse, Chiropractor, Dentist, Licensed Registered Dietician, Occupational Therapist, Physician, Physician Assistant, Podiatrist, Radiation Therapist, Respiratory Therapist and Speech Therapist.

1.52 **Prosthetic** - a fixed or removable device that replaces all or part of an extremity or body part, including such devices as an artificial limb, intraocular lens or breast prosthesis.

1.53 **Respite Care** - care provided to a Member receiving Covered Services for Hospice care, for the purpose of giving the Member's uncompensated primary caregivers relief when necessary in order to maintain the Member at home.

1.54 **Service Area** – The State of Arizona.

1.55 **Short-Term** - no longer than three (3) weeks.

1.56 **Skilled Care** - nursing or rehabilitative services requiring the skills of technical or professional medical personnel to develop, provide and evaluate the care and assess the Member's changing condition.

1.57 **Spouse** - An employee's or retiree's spouse is defined consistent with federal law to refer only to a person of the opposite sex who is a husband or a wife and not a domestic partner as that term is defined in this Plan. The Plan may require proof of the legal marital relationship. A spouse who is legally separated or divorced from the Subscriber is specifically excluded from the definition of Spouse.

1.58 **Subscriber** - an Eligible Employee whose enrollment form has been accepted, whose coverage is in force, in whose name the Membership Card is issued and who has not ceased to be a participant. A Subscriber also includes a former Employee (a retiree or COBRA participant) who is otherwise entitled to coverage and properly enrolled under the Plan.

1.59 **Summary Plan Description (SPD)**- a written summary of the benefits under the Plan.

1.60 **Urgent Care** - Health care services that are required by the onset of a medical condition that manifests itself by symptoms of sufficient severity that prompt medical attention is appropriate even though health and life is **not** in jeopardy.

SECTION II

ELIGIBILITY AND PARTICIPATION

2.1 **Eligibility for Employee Coverage**. Eligibility and participation are as follows for the Employer:

(a) **Eligible Employees**. An Employee is an Eligible Employee as long as he/she is actively at work in a full-time benefited position or who is a job-share or part-time leave benefited employee for the Employer, or a City Council member. Eligibility is restricted to Employees in benefit-designated positions on the Employer's payroll system.

(b) **Coverage Start Date**. An Employee is an Eligible Employee on the first day of the employment or change to eligible status with the Employer.

(1) If the Employee works for the Employer on the effective date of this Plan, the date of eligibility shall be the effective date of the Plan provided the above provisions are satisfied at that time.

(c) **FMLA Members**. A Subscriber whose coverage terminates during a qualified leave under the FMLA by reason of the Subscriber's election or due to nonpayment of required Employee contributions, will be immediately eligible to participate in the Plan on the date he/she returns to employment as an Eligible Employee directly from the FMLA leave.

(d) **Military Leave Members**. A Subscriber whose coverage is terminated by reason of military service under the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time, and who is reemployed by the Employer within the time allowed by law, will be immediately eligible to participate in the Plan on the date he/she returns to employment as an Eligible Employee.

(e) **Leave of Absence.** Employees who would normally be working as a regular Employee for the Employer for at least the required number of hours per pay period to qualify as an Eligible Employee, but who are on an Employer approved leave of absence, Including FMLA absences, remain Eligible Employees.

2.2 **Eligibility for Dependent Coverage**. Eligible Dependents are eligible for coverage under the Plan at the same time Eligible Employees are eligible for coverage under the Plan, or at the time the Eligible Employee first gains a Dependent, whichever occurs first, except in the case of a Medical Support Order (MSO).

A Dependent whose coverage is required under a MSO will be eligible to participate in the Plan as of the date specified in the order, provided the MSO satisfies the requirements of applicable law. The Employer will review a MSO and determine whether it satisfies the requirements of applicable law.

2.3 **Retiree Coverage**. Retired employees and retired members of the City Council who are under age 65 and who draw benefits within 60 days of retirement under the Arizona State Retirement

system, the Public Safety Retirement System or the Elected Officials Retirement System and are not eligible for Medicare/Medicaid benefits are eligible to continue coverage under the Plan for the retiree and eligible Dependents. Coverage for retirees will end effective the first (1st) day of the month in which the earliest of the following events occurs:

(a) The retiree reaches age 65.

(b) The retiree dies.

(c) The retiree opts out of such coverage.

(d) The retiree fails to pay necessary premiums to the Employer within established payment schedule as communicated directly to the retiree.

During the retiree's continuation period, the retiree has the same rights to add Dependents as outlined for Employees in 2.4 b, d, and e.

2.4 **Enrollment**. The following paragraphs describe enrollment. Please note that for an Eligible Employee's Dependents to be enrolled, the Eligible Employee must be enrolled or enrolling.

(a) **Initial Enrollment**. An Eligible Employee has thirty-one (31) days from the date he/she first satisfies the definition of Eligible Employee to enroll for coverage in the Plan. This is called the initial enrollment period. Enrollment materials are available from the Human Resources Department of the Employer. The eligible employee must request enrollment in the Plan within 31 days of becoming eligible for benefits by contacting the HR Department and indicating a request to enroll. The employee will then be provided with enrollment materials that must be completed and returned to the Employer or its designee in order to allow the payment of any claims. If the request for enrollment does not occur within this initial 31-day period, the Eligible Employee must wait until the next open enrollment period unless a "special enrollment" situation occurs.

A similar rule applies with respect to Dependents. A Dependent must request enrollment within thirty-one (31) days from the date he/she first satisfies the definition of Dependent, following the same process as outlined above for employees. If the request for enrollment does not occur within this initial period, the dependent must wait until the next open enrollment period unless a "special enrollment" situation occurs.

(b) **Open Enrollment**. Prior to the start of a Coverage Year, the Plan has an open enrollment period. "Open enrollment period" means the period of time, announced by the Employer, occurring toward the end of the Coverage Year during which Eligible Employees, Retirees and Dependents may do any of the following:

1. Enroll in the Plan if not previously covered under the Plan
2. Add or delete or change benefit options
3. or make any other changes announced during open enrollment

Newly elected benefits will become effective the first day of the upcoming Coverage Year. The terms of the open enrollment period, including duration of the election period, shall be determined by the Employer and communicated prior to the start of an open enrollment.

(c) **Opt Out**. An Eligible Employee may elect to waive coverage under the Plan. To do so you must submit to the HR department the completed written portion of the enrollment form that pertains to waiving coverage. Full-time employees must provide proof of other coverage in order to waive medical coverage. Remember that a Dependent may not be enrolled for coverage unless the employee is also enrolled. If, at a later date, you want the coverage you declined for yourself you may enroll only under the Special Enrollment provisions (when applicable) or the Open Enrollment provisions described later in this chapter. Note that no additional compensation is paid to you if you waive/decline benefit coverage.

(d) **Special Enrollment due to Loss of Other Health Coverage**. Under certain circumstances, an Eligible Employee or his/her Dependent who did not enroll during the initial enrollment period may enroll before the next open enrollment period. These circumstances warrant "special enrollment." Special enrollment shall be allowed for either of the following:

(1) The Eligible Employee, Retiree or the Dependent satisfies all of the following criteria:

a) Was covered under a group health plan or health insurance coverage (this prior coverage does not include continuation coverage required under federal law) at the time the Eligible Employee or Dependent was first eligible to enroll under the Plan;

b) Declined coverage in writing for that reason;

c) Presents to the Employer evidence of a loss of the prior coverage due to a loss of eligibility for that coverage, or evidence of the termination of employer contributions toward that coverage ("loss of eligibility" includes loss of eligibility as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment; but it does not include a loss due to the failure of the Eligible Employee or Dependent to pay premiums on a timely basis or termination of the prior coverage for cause); and

d) Notifies the Employer in writing within thirty (30) days of the date of the loss of coverage or the date the employer's contribution toward that coverage terminates.

(2) The Eligible Employee or Dependent satisfies all of the following criteria:

a) Was covered under benefits available under COBRA;

b) Declined coverage for that reason;

c) Presents to the Employer evidence that the Eligible Employee has exhausted such COBRA coverage and has not lost such coverage due to the failure of the Eligible Employee or Dependent to pay premiums on a timely basis or termination of coverage for cause; and

d) Notifies the Employer in writing within thirty (30) days of the date of the loss of coverage.

(e) **Special Enrollment Due to Addition of Dependent**. An Eligible Employee's marriage or the birth, adoption, placement for adoption, or legal guardianship of an Eligible Employee's child triggers special enrollment rights.

(1) **Non-Participating Employees May Also Enroll**. The addition of a new Dependent triggers enrollment rights for an Eligible Employee even if he/she does not participate in the Plan at the time of the event. For example, upon the birth of an Eligible Employee's child, the Eligible Employee (assuming that he/she did not previously enroll), his/her Spouse, and his or her newborn child may all enroll because of the child's birth. The same rule applies to the Eligible Employee's marriage or adoption of a child if the Eligible Employee had not previously enrolled in the Plan.

(2) **Deadline for Special Enrollment Period**. The Eligible Employee must request special enrollment in the Plan within thirty (30) days of marriage or birth, adoption or placement for adoption of his/her child. If the Employer, or its designee, does not receive the eligible Employee's completed request for enrollment within this deadline, the Eligible Employee and his/her dependents lose special enrollment rights for that event.

(f) **Change in Status**. Federal regulations generally require that your plan coverage remain in effect throughout the plan year. However, some changes may be allowed during the plan year if the Plan administrator determines that the individual has a qualifying change in status affecting their benefit needs. The change in coverage must be consistent with the change in status. As a result of a qualified status change, you may add or delete dependents from your coverage but you may not change plans. A qualified change in status is:

- Your marriage, divorce, legal separation or annulment;
- The birth or adoption of a child;
- The death of your spouse or child;
- A change in the number of your dependents;
- A change in employment status for you, your spouse or your dependent; or
- The beginning or end of an unpaid leave of absence taken by you or your spouse.

Whenever you have a qualified change in status, you must report the change by completing a change form, available from your Human Resources representative. The completed change form must be given to your Human Resources representative within 30 days of the event. Otherwise, you must wait until your employer's next open enrollment period.

2.5 **Effective Date of Coverage**. The date on which coverage becomes effective depends upon when enrollment occurs.

(a) **Enrollment Within Initial Enrollment Period**. The effective date of coverage for Subscribers who enroll during the initial enrollment period is the first day of the Eligible Employee's first day of employment or change to eligible status with the Employer. The effective date of coverage for Dependents is at the time of the Eligible Employee's enrollment.

If Dependent status is acquired after the Subscriber's initial eligibility, the effective date of coverage shall be the date on which the new Dependent becomes eligible for coverage under the Plan, provided the Subscriber completes a change form and submits it to the Employer within thirty (30) days after the attainment of Dependent status. Claims cannot be paid until the proper enrollment forms have been completed and submitted to the HR Department.

(b) **Enrollment Not Within Initial Enrollment Period**. If an Eligible Employee or Dependent does not enroll within the initial enrollment period, he or she must wait until the next open enrollment period unless a "special enrollment" situation occurs. The effective date of coverage would be the first day of the Coverage Year for which the open enrollment period was held.

(c) **Special Enrollment**. When enrollment occurs as the result of a special enrollment due to loss of other health coverage as described above, the effective date of coverage is the first day of the month following the request for enrollment. The Employer or its designee cannot consider claims until receipt and acceptance of the completed enrollment materials. When enrollment occurs as the result of a special enrollment due to addition or adoption of a child as described above, the effective date of coverage is the date of the event.

There is no late enrollment provision under this plan. Refer to Special Enrollment or Open Enrollment.

(d) Change **in Life Status**. When enrollment occurs as the result of a qualified change in life status, the effective date of the coverage is the date of the life event.

Note: Newborn children are automatically covered for 31 days after birth. To continue the coverage beyond 31 days, you must request enrollment for that child from your Human Resources representative within the 31-day period. Claims cannot be considered until completed enrollment material has been submitted.

The Plan does not have any pre-existing condition limitation provisions.

2.6 Family and Medical Leave (FMLA)

If your employer grants you an approved family or medical leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA), you may continue coverage for yourself and your eligible dependents during your approved leave. You must agree to make any required contributions.

The continued coverage will cease when:

- You fail to make any required contribution;
- Your approved leave is determined by your employer to be terminated; or
- The Plan is discontinued.

In addition, any coverage for a dependent will not be continued beyond the date it would otherwise terminate.

If you do not return to work at the end of the approved leave, your employer may recover from you the cost of maintaining your benefits coverage during the entire period of the leave, unless the failure to return to work was for reasons beyond your control.

If coverage under the Plan terminates because your approved FMLA leave is deemed terminated, you may, on the date of termination, be eligible to continue coverage under COBRA on the same terms as though your employment terminated on that date. If, however, your employment is terminated because of your gross misconduct, you will not be eligible for COBRA continued coverage. Contact your HR Department for more information on FMLA.

2.7 Leave for Military Service/Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you go into active military service for **up to 31 days**, you can continue your health care coverage under this Plan during that leave period if you continue to pay your contributions for that coverage during the period of that leave. If you go into active military service for **more than 31 days**, you should receive military health care coverage at no cost; however, you may also continue this group health plan coverage under the provisions of USERRA, at your own expense, as follows:

- If you elect USERRA continuation coverage **before** December 10, 2004 the maximum period for this coverage is up to 18 months.
- If you elect USERRA continuation coverage on or after December 10, 2004 the maximum period for this coverage is up to 24 months.

When your coverage under this Plan terminates because of your reduction in hours due to your military service, you and your eligible dependents may also have COBRA rights. See also the COBRA chapter of this document. Any coverage that was terminated will be reinstated immediately upon return to active employment. Questions regarding your entitlement to this leave and to the continuation of health care coverage should be referred to the HR Department

2.8 Membership Card. The Membership Card (also called ID card) issued by the Plan to a Member pursuant to this Plan is for identification purposes only. Possession of a Membership Card confers no right to services or benefits under this Plan, and misuse of such Membership Card may be grounds for termination of a Member's coverage under this Plan. To be eligible for services or benefits under this Plan, the holder of the Membership Card must be a Member. Any person receiving services or benefits, which he/she is not entitled to receive pursuant to the provisions of this Plan, will be charged for such services or benefits at prevailing rates. If any

Member permits the use of his/her Membership Card by any other person, such card may be retained by the Plan, and all rights of such Member pursuant to this Plan may be terminated.

2.9 **Subscriber Termination of Coverage**. Except as provided in the *Continuation of Healthcare Coverage* section, a Subscriber's participation under the Plan will cease at midnight on the last day in which the earliest of the following events occurs:

(a) The date the Subscriber terminates employment with the Employer.

(b) The date the Subscriber's employment position or status changes such that he/she is no longer an Eligible Employee.

(c) The date ending the period for which the last contribution is made if the Subscriber fails to make any required contributions when due.

(d) The date the Employer terminates this Plan or its participation in this Plan.

(e) The date of the Subscriber's death.

2.10 **Dependent Termination of Coverage**. Except as provided in the *Continuation of Healthcare Coverage* section, a Dependent's participation under the Plan will cease at midnight on the last day in which the earliest of the following events occurs:

(a) The date the dependent ceases to be an eligible Dependent as defined in the Plan.

(b) The date of termination of the Subscriber's coverage under the Plan (see above).

(c) The date the Dependent becomes covered under this Plan as a Subscriber.

(d) For Dependents whose coverage is required pursuant to a Medical Support Order, the last day coverage is required under the terms of the Medical Support Order or this Plan.

(e) The date the member enters the Armed Forces on active duty (except for active duty of 31 days or less).

2.11 **Member Termination of Coverage**. Except as provided in the *Continuation of Healthcare Coverage* section, any Member's participation under the Plan will cease at midnight on the last day in which the earliest of the following events occurs:

(a) The date a Member does not cooperate with the Employer with respect to the administration of this Plan. Failure to cooperate may result in a loss of eligibility for that Member and all Members with the same Membership Card. Such determination shall be made at the discretion of the Employer.

(b) The date on which a Member allows persons not covered under this Plan to obtain Plan benefits for themselves. See *Membership Card* subsection above.

(c) The date on which a Member provides fraudulent information to obtain Plan benefits or coverage, Including falsifying information on his/her applications for coverage and/or submitting fraudulent, altered or duplicate billings for his/her personal gain. If any claims are mistakenly paid for expenses incurred due to such fraudulent information, then the Member will be required to reimburse the Plan for any claims mistakenly paid.

(d) The date the Maximum Lifetime Benefit has been paid.

(e) The date the Member enters the Armed Forces on active duty (except for temporary active duty of 31 days or less).

2.12 HIPAA CERTIFICATION OF CREDITABLE COVERAGE WHEN COVERAGE ENDS

When your coverage ends, you and/or your covered Dependents are entitled by law to and will automatically be provided (free of charge) with a Certificate of Coverage that indicates the period of time you and/or they were covered under the Plan. Such a certificate will be provided to you shortly after the Plan knows or has reason to know that coverage for you and/or your covered Dependent(s) has ended. You can present this certificate to your new employer/health plan to offset a pre-existing condition limitation that may apply under that new plan or use this certificate when obtaining an individual health insurance policy to offset a similar limitation.

Procedure for Requesting and Receiving a Certificate of Creditable Coverage: A certificate will be provided upon receipt of a written request for such a certificate that is received by the Plan Administrator within two years after the date coverage ended under this Plan. The written request must be mailed or faxed to the Plan Administrator (in care of the HR Department) and should include the names of the individuals for whom a certificate is requested (including spouse and dependent children) and the address where the certificate should be mailed. A copy of the certificate will be mailed by the Plan to the address indicated. See the COBRA chapter for an explanation of when and how certificates of coverage will be provided after COBRA coverage ends.

SECTION III

CONTINUATION OF HEALTHCARE COVERAGE

3.1 Cobra Continuation of Coverage

You and your dependents have the right under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) to continue medical coverage under certain circumstances (called "qualifying events") when you would otherwise lose coverage. To do so, you must pay up to 102% of the full regular cost of coverage.

Continuation of Coverage Following Termination of Employment or Loss of Eligibility

You and your eligible dependents (but not domestic partners) are eligible to continue coverage for up to 18 months if:

- You leave your employer for any reason other than gross misconduct and you had health care coverage through your employer at the time you left employment; or
- You are no longer eligible because your working hours are reduced and you had health care coverage through your employer at the time your hours are reduced.

You may elect to continue coverage for yourself and your dependents, or your dependents may each elect to continue their own coverage.

If you or your dependent is disabled, as defined by the Social Security Administration, at the time of the qualifying event or becomes disabled within 60 days of the event, you may be entitled to an extra 11 months of coverage, for a total of 29 months. You must notify your Human Resources representative of the disability before the end of the original 18-month period to receive the extension, and you must pay up to 150% of the full cost of coverage for every month after the 18th month. Coverage may be continued for the disabled individual and for any family member for whom coverage is already being continued under COBRA, as well as for your newborn or newly adopted child who was added after the date COBRA continuation began. COBRA continuation of benefits will end on the first day of the month that begins more than 30 days after the final determination under Title II or XVI of the Social Security Act that the disabled individual is no longer disabled.

Continuation of Coverage Due to Other Qualifying Events

Your eligible dependents can continue coverage for up to 36 months if coverage would otherwise cease because:

- You die;
- You are divorced;
- You stop making contributions for a spouse from whom you are legally separated;
- You become entitled to Medicare;
- A covered child is no longer eligible under the Plan.

If one of the above events occurs while you or a covered dependent have already continued coverage due to the termination of your employment or your loss of eligibility, your dependent may extend coverage beyond the original 18-month continuation period, but for no more than a total of 36 months from the date coverage would originally have ended.

Applying for COBRA Continuation

Your Human Resources representative will give you information about how to continue COBRA coverage at the time you become eligible.

You must inform your employer of any status changes that would make your dependents eligible for COBRA coverage within 60 days of the later to occur of:

- The occurrence of the event; and
- The date coverage would terminate due to the event.

To ensure that there is no break in coverage, the election to continue coverage under COBRA must be made within 60 days of:

- The date coverage would terminate due to the event; or
- The date your employer informs your dependents of their right to continue coverage; whichever happens later.

If you do not make an election within 60 days, you will lose your COBRA continuation rights.

Special Enrollment Rights

You have special enrollment rights under federal law that allows you to request special enrollment under another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying events listed in this chapter. The special enrollment right is also available to you if you continue COBRA for the maximum time available to you.

Procedure for Notifying the Plan of a Qualifying Event (Very Important Information)

In order to have the chance to elect COBRA Continuation Coverage after a divorce, legal separation, or a child ceasing to be a "dependent child" under the Plan, **you and/or a family member must inform the Plan in writing of that event no later than 60 days after that event occurs.** That written notice should be sent to the Plan Administrator whose address is listed in this document. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the qualifying event, the date of the event, and appropriate documentation in support of the qualifying event, such as divorce documents.

Grace Periods

The initial payment for the COBRA Continuation Coverage is due to the Plan Administrator 45 days after COBRA Continuation Coverage is elected. If this payment is not made when due, COBRA Continuation Coverage will not take effect. After the initial COBRA payment, subsequent payments are due on the first day of each month, but there will be a 30-day grace

period to make those payments. If payments are not made within the time indicated in this paragraph, COBRA Continuation Coverage will be canceled as of the due date. Payment is considered made when it is postmarked.

Confirmation of Coverage Before Election or Payment of the Cost of COBRA Continuation Coverage

If a Health Care Provider requests confirmation of coverage and you, your Spouse or Dependent Child(ren) have elected COBRA Continuation Coverage and the amount required for COBRA Continuation Coverage has not been paid while the grace period is still in effect **or** you, your Spouse or Dependent Child(ren) are within the COBRA election period but have not yet elected COBRA, COBRA Continuation Coverage will be confirmed, but with notice to the Health Care Provider that the cost of the COBRA Continuation Coverage has not been paid, that no claims will be paid until the amounts due have been received, and that the COBRA Continuation Coverage will terminate effective as of the due date of any unpaid amount if payment of the amount due is not received by the end of the grace period.

Addition of Newly Acquired Dependents

If, while you (the employee or retiree) are enrolled for COBRA Continuation Coverage, you marry, have a newborn child, adopt a child, or have a child placed with you for adoption, you may enroll that spouse or child for coverage for the balance of the period of COBRA Continuation Coverage if you do so within 31 days after the marriage, birth, adoption, or placement for adoption. Adding a Spouse or Dependent Child may cause an increase in the amount you must pay for COBRA Continuation Coverage. Contact the Plan Administrator to add a dependent.

Loss of Other Group Health Plan Coverage

If, while you (the employee or retiree) are enrolled for COBRA Continuation Coverage your spouse or dependent loses coverage under another group health plan, you may enroll the spouse or dependent for coverage for the balance of the period of COBRA Continuation Coverage. The spouse or dependent must have been eligible but not enrolled in coverage under the terms of the pre-COBRA plan and, when enrollment was previously offered under that pre-COBRA healthcare plan and declined, the spouse or dependent must have been covered under another group health plan or had other health insurance coverage.

The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause. You must enroll the spouse or dependent within 31 days after the termination of the other coverage. Adding a Spouse or Dependent Child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

Notice of Unavailability of COBRA Coverage

In the event the Plan is notified of a qualifying event but determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent, by the Plan Administrator an explanation indicating why COBRA coverage is not available. This notice of the unavailability of COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

Notice of Early Termination of COBRA Continuation Coverage

The Plan will notify a qualified beneficiary if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the qualifying event that entitled the individual to COBRA coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period, the date COBRA coverage terminated and any rights the qualified beneficiary may have under the Plan to elect alternate or conversion coverage. The notice will be provided as soon as practicable after the Plan Administrator determines that COBRA coverage will terminate early.

When COBRA Continuation Coverage Ends

Continuation coverage will end on the earliest date that:

- The COBRA continuation period expires.
- You or your family members do not make the required contributions in a timely manner.
- You or your family members become covered under another group health plan, unless that plan contains a provision that restricts the payment of benefits for a pre-existing condition. Once the pre-existing condition clause of the new plan ceases to apply, your COBRA coverage will cease.
- The date, after the election of COBRA that you or your family members become enrolled in Medicare.
- Your employer terminates this health plan.
- The date the lifetime benefit maximum is exhausted on all benefits.
- During an extension of the maximum coverage period to 29 months due to the disability of the covered person, the disabled person is determined by the Social Security Administration to no longer be disabled

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, your employer will give you a certificate confirming your participation in the Plan when your health coverage terminates under the Plan and if elected, under COBRA. MMSI will assist your employer with the preparation and distribution of the certificates. Certificates can be obtained from your Human Resources representative.

HIPAA Certification Of Creditable Coverage When Coverage Ends

When your COBRA coverage ends, the Plan Administrator will automatically provide you and/or your covered Dependents (free of charge) with a Certificate of Coverage that indicates the period of time you and/or they were covered under the Plan. If your coverage under this Plan ends, and you and/or your covered Dependents become eligible for coverage under another group health plan, or if you buy, for yourself and/or your covered Dependents, a health insurance policy, you may need this certificate (to prove that you did not have a break in coverage of 63 consecutive days or more) in order to reduce any exclusion for Pre-Existing Conditions that may apply to you and/or your covered Dependents in that new group health plan or health insurance policy. The certificate will indicate the period of time you and/or they were covered under this Plan, and certain additional information that is required by law.

The certificate will be sent to you (or to any of your covered Dependents) by first class mail shortly after your (or their) coverage under this Plan ends. This certificate will be in addition to any certificate provided to you after your pre-COBRA group health coverage terminated. In addition, a certificate will be provided to you and/or any covered Dependent upon receipt of a written request for such a certificate if that request is received by the Plan Administrator within two years after the later of the date your coverage under this Plan ended or the date COBRA coverage ended.

SECTION IV

UTILIZATION MANAGEMENT

4.1 **Introduction**. This section describes utilization management programs under the Plan and the Member's responsibilities under these programs. Utilization management programs assist Members to ensure maximum benefit coverage while optimizing clinical outcomes across a continuum of care.

(a) The utilization management programs are designed to assist the Plan in:

(1) evaluating Members' Healthcare Services for Medical Necessity and appropriateness

(2) evaluating alternate level of care opportunities

(3) coordinating care needs

(4) identifying benefit limitations

(5) identifying high risk Members for proactive case management.

(b) The Plan uses the methods described in this *Utilization Management* section to coordinate and review care, and to determine whether services are Covered Services under the Plan.

4.2 **Utilization Management Criteria**. Members will receive benefits under the Plan only for Covered Services that are determined to be Medically Necessary and not Experimental or Investigative. The fact that an individual Healthcare Provider has prescribed, ordered, recommended, or approved a Healthcare Service, or has informed the Member of its availability does not in itself make it Medically Necessary. The Plan will make the final determination of whether any service constitutes Medically Necessary Care or is considered Experimental or Investigative.

4.3 **Medical Care Decisions**. The Member's medical care is between the Member and the Member's Healthcare Provider. The Member and the Member's Healthcare Provider must make the ultimate decision on the Member's medical care. The Plan only has authority to determine whether provided services are Covered Services for purposes of payment under this Plan.

4.4 **Out of Network.** The Member is entitled to coverage from Out-of-Network Healthcare Providers. Benefits are paid per the *Schedule of Benefits* section.

4.5 **Prior Authorization**. Prior Authorization is authorization from the Plan for specific Covered Services before they are rendered, in accordance with this *Utilization Management* section.

(a) Limitations.

(1) Prior Authorization does not guarantee that proposed Healthcare Services are covered (e.g., payable) under the Plan. Coverage for authorized services is subject to the definitions, conditions, limitations and exclusions of this Plan.

Services provided after Prior Authorization is received may be subject to further review by the Plan to ensure the services are Medically Necessary. Benefits will be denied if the Member is not eligible for coverage under this Plan on the date services are incurred, if services received are not Medically Necessary, or if the Plan terminates.

(2) Prior Authorization does not determine the level at which benefits will be available.

(b) Certain Covered Services Require Prior Authorization. Certain Covered Services require Prior Authorization under this Plan, Including:

(1) **Durable Medical Equipment, Orthotics or Prosthetics over $750**.

Please note: Prior Authorization is not required for oxygen and oxygen supplies.

(2) **Certain elective surgeries**, Including:

a) **Back surgery**.

Please note: Prior Authorization is not required for the following back surgeries:

- *laminectomy*
- *discectomy*
- *epidural injections or discogram*
- *osteotomy or arthrodesis of the spine*
- *decompression*
- *vertebral corpectomy*

b) **Breast surgery**.

Please note: Prior Authorization is not required for any surgery related to cancer treatment or reconstruction following a mastectomy for breast cancer treatment.

c) **Cosmetic or reconstructive procedures and surgery**.

Please note: Prior Authorization is not required for reconstruction following a mastectomy for breast cancer treatment.

d) **Blepharoplasty, brow lifts or keratoplasty**.

e) **Rhinoplasty, septoplasty or rhinoseptoplasty**.

f) **Oral surgery, maxillofacial surgery or uvulopalatopharyngoplasty (UPPP)**.

Please note: Prior Authorization is not required for oral surgery for treatment of cancer.

g) **Foot surgery**.

Please note: Prior Authorization is not required for foot surgery if there has been prior conservative treatment.

h) **Varicose vein treatment**.

Please note: Prior Authorization is <u>not</u> required for stripping and ligation of varicose veins.

i) **Weight reduction surgery**.

(3) **Home Health Care**.

(4) **Hospice care**.

(5) **Mental health and chemical dependency outpatient treatment after ten (10) outpatient visits for each per Member per Coverage Year**.

(6) **Non-Emergency Hospital Admissions**, Including admissions for mental health, chemical dependency or medical procedures.

Please note: Prior Authorization is <u>not</u> required for emergency admissions to the Hospital; however, the Member should notify the Claims Administrator within 48 hours after the admission or as soon as reasonably possible. Note: for pregnant women, prior authorization is required only for hospital stays that last or are expected to last longer than 48 hours for a vaginal delivery and 96 hours for a C-section

(7) **Psychological testing**.

(8) **Residential structured and non-residential structured treatment programs for mental health and chemical dependency**.

(9) **Skilled Nursing Facility**.

(10) **Temporomandibular joint disorder (TMJ/TMD) treatment**.

(11) **Transplants**, Including organ transplants, bone marrow transplants and stem cell transplants.

(12) **Infertility services *as noted in the Schedule of Benefits Section***

(c) **<u>How to Obtain Prior Authorization</u>.**

(1) <u>In-Network Healthcare Providers</u>. When a Member seeks Covered Services from an In-Network Healthcare Provider, compliance with the Prior Authorization requirements is the Healthcare Provider's responsibility

(2) <u>Out-of-Network Healthcare Providers</u>. When a Member seeks Covered Services from an Out-of-Network Healthcare Provider, compliance with the Prior Authorization requirements is the Member's responsibility. (a) When a Member seeks Covered Services from an Out-of-Network Healthcare Provider, the Member is responsible to initiate Prior Authorization by having the Out-of-Network Healthcare Provider contact the Claims Administrator to request Prior Authorization on behalf of the Member. (b) The Claims Administrator will issue a notice of authorization, partial authorization or denial of authorization following review of the Prior Authorization request.

(d) Review. In cases where Prior Authorization is required but not obtained, such services will be subject to review to determine whether the services are Covered Services under the Plan.

(e) Complaints and Appeals if Prior Authorization is Denied. If Prior Authorization is denied in whole or in part, see the *Claims Payment and Appeal Procedure* section for a description of the complaint and appeal process.

4.6 Utilization Management. Utilization management is the process of reviewing certain services that have been requested or provided to evaluate:

(a) Medical Necessity.

(b) Verification that services are Covered Services under the Plan.

(c) Verification the Member obtained Prior Authorization or referral if required.

(d) Identification of case management or coordination of care needs.

4.7 Discharge Planning. Discharge planning assists Members with the transition to an appropriate level of care following acute inpatient and/or outpatient Healthcare Services. If the Member is not able to return home, the Plan may coordinate or assist in the coordination of the Member's care to identify the most appropriate alternative setting and services.

4.8 Case Management. Case management is collaborative, systematic, and ongoing management of Members with complex diagnoses, catastrophic Injuries or Illnesses, chronic health problems, and/or poor histories of self-management or compliance. Case management involves coordination of the Member's healthcare needs and a treatment plan across the healthcare continuum.

4.9 Questions Regarding Utilization Management Procedures. If the Member has any questions regarding these procedures, the Member or the Member's Healthcare Provider should contact the Claims Administrator's Customer Service Department at the number listed in the *Introduction* section of this SPD.

SECTION V

SELECTING A HEALTHCARE PROVIDER

5.1 **Provider Directories**. Members will receive a list of Healthcare Providers in a separate document called the *Provider Directory*. Members may request additional copies of the Provider Directory and information regarding specific Healthcare Providers by calling the Claims Administrator's Customer Service Department at 1-866-206-5724.

5.2 **Healthcare Provider Status**. Enrolling in this Plan does not guarantee that a particular Healthcare Provider will remain a Healthcare Provider or that a particular Healthcare Provider will provide Members with Healthcare Services. Members should verify a Healthcare Provider's status each time Healthcare Services are received from the Healthcare Provider.

5.3 **Choice of Healthcare Provider**. The Member will have free choice of any legally qualified Healthcare Provider, and the Healthcare Provider-patient relationship will be maintained. If the Member chooses to receive Covered Services from an Out-of-Network Healthcare Provider, he or she may receive a lower level of benefits as described in the *Schedule of Benefits* section.

5.4 **Continuity of Care**. In the event that either a Member joins the Plan or a Healthcare Provider leaves the Plan, a Member may experience a disruption in services. Continuity of care provisions provide Members the opportunity to continue receiving treatment from his/her Healthcare Provider.

(a) The Plan allows a new Member to continue an active course of treatment for a life threatening disease or condition with a Healthcare Provider who is not an In-Network Healthcare Provider for a transitional period of thirty (30) days.

(b) In the event a new Member has entered the first (1^{st}) trimester of pregnancy, the Plan shall allow the Member to continue to receive care from a Healthcare Provider who is not an In-Network Healthcare Provider for a transitional period, Including delivery and any care up to six (6) weeks after the delivery that is related to the delivery.

(c) The Plan allows a Member to continue an active course of treatment for a life threatening disease or condition with a Healthcare Provider who was terminated from the provider network for a transitional period of thirty (30) days. In the event that the Healthcare Provider was terminated by a plan for reasons of medical incompetence or unprofessional conduct, the continuity of care provisions shall not apply.

(d) In order for the continuity of care provisions to apply, the Healthcare Provider must agree in writing to accept as payment in full reimbursement at the rates established by the Plan, comply with the Plan's quality assurance and utilization review requirements and comply with the Plan's policies and procedures relating to referrals and obtaining Prior Authorization.

(e) The Plan will not provide coverage for benefits not otherwise covered under this Plan.

SECTION VI

SCHEDULE OF BENEFITS

6.1 Cost Sharing and Benefits.

This *Schedule of Benefits* section details the Covered Services and related costs to the Member under this Plan. Your share of payment for your health care expenses is directly related to whether you receive services from an In-Network Preferred Care Provider (PPO) or an Out-of-Network non-Preferred Care Provider (Non-PPO). A greater portion of your medical expenses will be covered when you receive services from an In-Network PPO provider.

This *Schedule of Benefits* section is limited by the express exclusions and limitations set out in the *Exclusions* section.

Some Covered Services are subject to Prior Authorization requirements, as indicated in the *Utilization Management* section and this *Schedule of Benefits* section. Please refer to the *Utilization Management* section for a full description of Prior Authorization.

(a) Level of Benefits.

(1) The Member is responsible for the difference between Usual and Customary Rates and billed charges whenever an Out-of-Network Healthcare Provider provides Covered Services.

(2) Covered Services not available In-Network will be paid at the In-Network benefit level if Prior Authorization is obtained.

(3) Covered Services provided by an Out-of-Network Professional Healthcare Provider at an In-Network facility will be paid at the In-Network level of benefits.

(4) Out-of-Network benefits will be paid for Covered Services incurred at an Out-of-Network facility when admitted by an In-Network Physician.

(b) **Deductibles.**

	In-Network	**Out-of-Network**
Deductible	$500 per Member $1,000 per Family of 2 or more	$1,000 per Member $2,000 per Family of 2 or more

(1) Cost Sharing Amounts for Covered Services received from In-Network Healthcare Providers will apply to only the In-Network Deductible. Cost Sharing Amounts for Covered Services received from Out-of-Network Healthcare Providers will apply to the Out-of-Network Deductible.

(c) **Annual Out-of Pocket Maximums**.

	In-Network	Out-of-Network
Annual Out-of-Pocket Maximum for Medical Expenses	$3,000 per Member $6,000 per Family of 2 or more	$4,000 per Member $8,000 per Family of 2 or more

(1) Cost Sharing Amounts for Covered Services received from In-Network Healthcare Providers will apply to only the In-Network Annual Out-of-Pocket Maximum. Cost Sharing Amounts for Covered Services received from Out-of-Network Healthcare Providers will apply to the Out-of-Network Annual Out-of-Pocket Maximum.

(d) Maximum Benefits Paid by the Plan for Certain Covered Services. The Plan has established limits on the amount of benefits it will pay for certain Covered Services. These specific services and their applicable limits are identified in this *Schedule of Benefits* section. These maximum benefit amounts are included in the Maximum Lifetime Benefit.

(e) Maximum Lifetime Benefit Paid by the Plan.

	In-Network	Out-of-Network
Maximum Lifetime Benefit	$2,000,000 per Member	

6.2 **Covered Services**. This Section describes the Covered Services for which benefits are available under this Plan, subject to the definitions, exclusions, conditions and limitations of this Plan, Cost Sharing Amounts and Maximum Lifetime Benefits. In the charts that follow, benefits are described as to what a member must pay.

(a) AMBULANCE

Service	In-Network cost to Member	Out-of-Network cost to Member
Ambulance	**10% after Deductible**	**10% after Deductible**

Prior Authorization is required for coverage of certain Covered Services. See the *Utilization Management* section for details on how to obtain Prior Authorization.

Covered Services include:

- Emergency Ambulance Service. No Prior Authorization is required for Emergency Ambulance Service.
- Air Ambulance charges to the nearest network facility when it is the only Medically Necessary means of transporting the Member.
- Ambulance services for an Emergency even if the Member is not transported.
- Non-Emergency Ambulance services when Medically Necessary and when Prior Authorization is obtained.

In addition to Cost Sharing Amounts, the Member will also be responsible for any charges above Usual and Customary Rates when receiving Covered Services Out-of-Network.

(b) CHIROPRACTIC SERVICES

Service	In-Network cost to Member	Out-of-Network cost to Member
Chiropractic Services	**10% after Deductible**	**30% after Deductible**

Coverage is provided only for those services that are Medically Necessary and is subject to the Coinsurance listed above. Coverage is provided for non-surgical and non-invasive treatment of neck and back pain through physiotherapy, musculoskeletal manipulation and other physical corrections of musculoskeletal conditions within the scope of the chiropractic practice.

The maximum annual benefit for chiropractic services is 20 visits per Member per Coverage Year. For chiropractic services, In-Network shall mean the ASHN Chiropractic Network as included in the MMSI Provider Directory.

In addition to Cost Sharing Amounts, the Member will also be responsible for any charges above Usual and Customary Rates when receiving Covered Services Out-of-Network.

(c) DENTAL SERVICES AND ORAL SURGERY

Service	In-Network cost to Member	Out-of-Network cost to Member
Dental Services and Oral Surgery	**10% after Deductible**	**30% after Deductible**

Prior Authorization is required for coverage of certain Covered Services. See the *Utilization Management* section for a list of these services and details on how to obtain Prior Authorization.

The Plan covers treatment of acute, accidental, traumatic injuries to teeth (including replacement of evulsed teeth due to traumatic complications) or jaws. This does not include Injury from biting or chewing. Charges incurred for crowns, bridges, dentures, or other fixed or removable dental prosthetic devices are not covered unless in accordance with an approved treatment plan. Dental implants are not covered.

Coverage for oral surgery is very limited. However, the following are Covered Services under the Plan:

- Oral surgical treatment of, and orthodontic services related to the management of, cleft lip or cleft palate. Dental services that are not required for the treatment of cleft lip or cleft palate are not covered under this provision.
- Oral surgery for tumors or cysts of the jawbone or mouth (excluding restorative or orthodontic treatment that may or may not be related to the tumor or cyst).
- Oral surgery for partial or complete bony impaction of teeth, but not repair, restoration, or extraction of erupted teeth or teeth impacted under soft tissue only.
- Surgical or non-surgical treatment of temporomandibular joint disorders (TMJ) by a Physician or a Dentist. This provision excludes coverage for dental services required for the treatment of TMJ such as replacement of missing teeth, replacement of defective fillings, replacement of unsatisfactory dentures or prostheses, or corrections of malocclusion. Services provided for cosmetic or dental reasons are not covered, Including orthodontic treatment, dental restorations, or fixed or removable prostheses. Oral splints for the treatment of TMJ are covered under the Member's Durable Medical Equipment (DME) benefit and are limited to one (1) splint per Member per Coverage Year.

In addition to Cost Sharing Amounts, the Member will also be responsible for any charges above Usual and Customary Rates when receiving Covered Services Out-of-Network.

(d) DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND DISPOSABLE SUPPLIES

Service	In-Network cost to Member	Out-of-Network cost to Member
Durable Medical Equipment, Prosthetics, Orthotics and Disposable Supplies	**10% after Deductible**	**30% after Deductible**

Prior Authorization is required for coverage of certain Covered Services. See the *Utilization Management* section for a list of these services and details on how to obtain Prior Authorization.

The following types of equipment are covered, but only if (1) prescribed by a Healthcare Provider and (2) approved by the Plan for use outside of a Hospital, Rehabilitation Facility, or Skilled Nursing Facility. The Plan's payment for such equipment is limited to the least expensive, medically appropriate Prosthetic, Orthotic, or Durable Medical Equipment (DME) required to fulfill the prescription. If a Member chooses to rent or purchase a Prosthetic, Orthotic, or piece of Durable Medical Equipment (DME) costing more than the option covered by the Plan, the Member shall be responsible for the additional cost.

The maximum annual benefit for Durable Medical Equipment, Prosthetics, Orthotics and Disposable Supplies is $10,000 aggregate per Member per Coverage Year. The Plan reserves the right to determine if an item will be approved for rental versus purchase. The Plan's payment for rental shall not exceed the purchase price.

Services and supplies not specifically addressed or described, as a Covered Service will be considered for coverage according to Medicare guidelines.

Covered Services Include:

a. Removable, non-dental prosthetic devices which are durable and custom-made for the Member, but which do not require surgical connection to nerves, muscles, or other tissue.

b. Trusses and orthopedic appliances, which are durable and custom-made for the Member. Foot orthotics, when they are durable and custom-made for the Member, are limited to one (1) pair per Member per Coverage Year. Orthopedic footwear and orthopedic shoes as associated with diabetes are covered.

c. A semi-rigid penile prosthesis or external pump is covered for the correction of sexual dysfunction resulting from organic (i.e., not psychogenic) factors. When considered a Covered Service, coverage is limited to the least expensive option.

d. The fitting and purchase of the first set of contact lenses following surgery for aphakia, limited to one (1) per Member per lifetime. The fitting and purchase of one (1) set of contact lenses for keratoconus per Member per Coverage Year is covered.

e. Home renal dialysis equipment and supplies.

f. Equipment necessary to treat respiratory failure. Room air conditioners, room humidifiers, room dehumidifiers and other comfort items are not covered. Apnea monitors for adults and infants are covered if Prior Authorized.

g. The following diabetic supplies for insulin-treated Members: blood glucose monitors Including blood glucose monitors for the legally blind, test strips for glucose monitors and visual reading, urine test strips, insulin preparations and glucagon, insulin cartridges Including insulin cartridges for the legally blind, drawing up devices and monitors for the visually impaired, injection aids, syringes and lancets Including automatic lancing devices.

h. Holter monitoring devices.

i. TENS units.

j. Oxygen and equipment for a supplemental oxygen delivery system.

k. A manually operated wheelchair, or a manually operated hospital-type bed. Prior Authorization is required for any wheelchair accessories beyond that of a basic, manually operated wheelchair.

l. Jobst sleeves, stockings, and gloves are covered only for post-phlebitic conditions or post-surgical edema, and coverage is limited to one (1) sleeve, stocking or glove per affected body part per Member per Coverage Year.

m. Cochlear implants for individuals who meet criteria set by the Food and Drug Administration for cochlear implants and for whom conventional amplification is of no significant benefit. Prior Authorization is required.

n. Bronchial drainage systems that employ a chest percussion vest and vest compressor (or other similar devices) subject to Prior Authorization.

o. Incidental to a covered mastectomy, up to two (2) Medically Necessary bras for breast prosthesis and up to two (2) external breast prostheses will be covered per Member per Coverage Year.

p. Removable dental splints that are durable and custom made for the Member for the treatment of TMJ. Limited to one (1) per Member per Coverage Year.

q. Cranial Remodeling Bands, subject to criteria determined by the Plan, please call the Claim's Administrator's Customer Service number for further information.

Disposable supplies, including those associated with covered equipment, are not covered except as noted above. Replacement or repair of these items which are (a) damaged or destroyed by misuse, abuse or carelessness, (b) stolen, or (c) lost, are not Covered Services. Replacement of these items is covered if they have outlived their useful life, or to accommodate bodily growth, as determined by the Plan. Duplicate or similar items are not covered.

In addition to Cost Sharing Amounts, the Member will also be responsible for any charges above Usual and Customary Rates when receiving Covered Services Out-of-Network.

(e) EMERGENCY SERVICES AND URGENT CARE SERVICES

Service	In-Network cost to Member	Out-of-Network cost to Member
Emergency Room	**$100 Copayment per visit and 10% after Deductible**	**$100 Copayment per visit and 10% after In-Network Deductible**
Inpatient Physician Services	**10% after Deductible**	**10% after In-Network Deductible**
Urgent Care Services	**$50 Copayment per visit and 10% after Deductible**	**$50 Copayment per visit and 10% after In-Network Deductible**

In the case of an Emergency, the Member should go to the nearest emergency care Healthcare Provider.

Emergency and Urgent Care Covered Services include:
- Institutional Healthcare Provider charges
- Professional Healthcare Provider charges
- diagnostic tests

If the Member is admitted directly to inpatient status from the Emergency room, the Copayment for the Emergency room services will be waived; follow-up services in the Emergency room are not Covered Services unless Medically Necessary.

Notification of Emergency hospitalization is required within 48 hours or as soon as reasonably possible. The responsibility for notification belongs to the Healthcare Provider when care is received In-Network. When care is received Out-of-Network, notification is the responsibility of the Member and is accomplished by contacting the Claims Administrator's Customer Service Department at 1-866-206-5724.

Expenses incurred due to an Emergency will be paid at the In-Network level of benefits.

(f) HOME HEALTH CARE

Service	In-Network cost to Member	Out-of-Network cost to Member
Home Health Care, 40 visits per Coverage Year	**10% after Deductible**	**30% after Deductible**

Prior Authorization is required for coverage of certain Covered Services. See the *Utilization Management* section for a list of these services and details on how to obtain Prior Authorization.

The following Part-Time or Intermittent skilled home nursing and therapeutic services, for conditions which would otherwise require Confinement in a Hospital or Skilled Nursing Facility, are Covered Services when rendered in the Member's home in accordance with the specified written treatment plan from an In-Network Healthcare Provider if the Member is homebound (i.e., unable to leave home without considerable effort due to a medical condition).

a. Skilled nursing services by a registered nurse or licensed practical nurse.
b. Home health aide services.
c. Laboratory services.
d. Physical, occupational, speech or respiratory therapy subject to limits of this Plan.
e. Home intravenous (IV) antibiotic therapy.
f. Necessary training for the primary caregiver(s) in the home.

Home health services are Covered Services only when they are rendered as rehabilitative (and not as maintenance, Custodial or respite care). Home hospice care is covered as outlined in the *Hospice Care* subsection of this *Schedule of Benefits* section.

Home health services are not provided as a substitute for a primary caregiver in the home or as relief (respite) for a primary caregiver in the home. The Plan will not reimburse family members or residents in the Member's home for the above services and will not provide these services at a school or any site other than the Member's home.

A service shall not be considered a skilled nursing service merely because it is performed by, or under the direct supervision of, a licensed nurse. When a service (such as tracheotomy suctioning or ventilator monitoring) or like services, can be safely and effectively performed by a non-medical person (or self-administered), without the direct supervision of a licensed nurse, the service shall not be regarded as a skilled nursing service, whether or not a skilled nurse actually provides the service. The unavailability of a competent person to provide a non-skilled service shall not make it a skilled service when a skilled nurse provides it. Only the skilled nursing components of so-called "blended" services (i.e., services which Include skilled and non-skilled components) are covered under this Plan.

In addition to Cost Sharing Amounts, the Member will also be responsible for any charges above Usual and Customary Rates when receiving Covered Services Out-of-Network.

(g) HOSPICE CARE

Service	In-Network cost to Member	Out-of-Network cost to Member
Hospice Care	**10% after Deductible**	**30% after Deductible**

Prior Authorization is required for coverage of certain Covered Services. See the *Utilization Management* section for a list of these services and details on how to obtain Prior Authorization.

The Plan will cover the services described below for Members who are terminally ill and are accepted into a home Hospice or Hospice facility program. Members must meet the eligibility requirements of the program and elect to receive services through the Hospice program. The services may be provided in the Member's home or the Hospice facility, with inpatient care available as described below. Members who elect to receive Hospice services do so in lieu of curative treatment for their terminal illness for the period they are enrolled in the Hospice program.

Eligibility. In order to be eligible to be enrolled in the Hospice program, a Member must:

(i) Be terminally ill;

(ii) Have chosen a palliative treatment focus (i.e., emphasizing comfort and supportive services rather than treatment attempting to cure the disease or condition); and

(iii) Continue to meet the other criteria established by the Hospice program for participation in the Hospice program.

A Member may withdraw from the Hospice program at any time.

Eligible Services. Hospice services Include the following services when provided in accordance with a written Hospice treatment plan.

(i) Home Health Services:

(a) Part-Time care provided in the Member's home by an interdisciplinary Hospice team (which may Include a Physician, Registered Nurse, Social Worker, home health aide, and spiritual counselor) are covered subject to the Coinsurance.

(b) One or more periods of Continued Care will be provided in the Member's home or in a setting, which provides day care for pain or symptom management. Charges are subject to the Coinsurance. The period or periods of Continued Care and respite care combined are limited to thirty (30) days per Member lifetime, and is conditional upon the Member being enrolled in a Plan approved home Hospice program.

(c) Respite care in an Institutional Healthcare Provider is covered. Respite care is limited to five (5) days during which twelve (12) or more hours of respite services are provided in an Institutional Healthcare Provider. The period or periods of respite care and Continued Care combined are unlimited while enrolled in the home Hospice program.

(ii) Inpatient Services

The Plan covers inpatient services.

Ineligible Services. The Plan does not cover the following services:

(i) Financial or legal counseling services;
(ii) Housekeeping or meal services in the Member's home;
(iii) Maintenance or Custodial Care related to hospice services, whether provided in the home or in a nursing home;
(iv) Any service not specifically described as a Covered Service under this Section; or
(v) Any services provided by members of the Member's family or residents in the Member's home.

In addition to Cost Sharing Amounts, the Member will also be responsible for any charges above Usual and Customary Rates when receiving Covered Services Out-of-Network.

(h) INFERTILITY SERVICES

Service	In-Network cost to Member	Out-of-Network cost to Member
Infertility Services	**10% after Deductible**	**30% after Deductible**

Prior Authorization is required for coverage of certain Covered Services. See the *Utilization Management* section for a list of these services and details on how to obtain Prior Authorization.

An infertility diagnostic evaluation limited to consultation, laboratory tests, and certain procedures limited to sperm count, hysterosalpingography, and endometrial biopsy, is a Covered Service.

All infertility services require prior authorization.

Services involving sperm acquisition and sperm storage charges; artificial insemination; reversal of surgical sterilization; treatment of infertility after reversal of sterilization; assisted reproduction Including but not limited to in vitro and in vivo fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), intracytoplasmic sperm injection (ICSI), use of donor egg, and experimental procedures; costs incurred by or for a non-Member surrogate's pregnancy (other than in the case of an adoption where all the requirements of Arizona Revised Statutes § 20-1057.K. and L. are met); and any related charges incurred for these excluded procedures are not covered.

Medications to treat infertility are not covered, including medications prescribed to prevent recurrent spontaneous abortions.

In addition to Cost Sharing Amounts, the Member will also be responsible for any charges above Usual and Customary Rates when receiving Covered Services Out-of-Network.

(i) INPATIENT AND OUTPATIENT HOSPITAL AND PHYSICIAN SERVICES

Service	In-Network cost to Member	Out-of-Network cost to Member
Primary Physician Office Visits	**$15 Copayment per visit**	**30% after Deductible**
Specialty Physician Office Visits	**$30 Copayment per visit**	**30% after Deductible**
Outpatient Lab & X-Ray	**10% after Deductible**	**30% after Deductible**
Inpatient Hospital Services (Non-Emergency)	**10% after Deductible**	**30% after Deductible**
Physician Visit and Related Services	**10% after Deductible**	**30% after Deductible**
Outpatient Hospital, Ambulatory Care, Office Surgeries or Surgical Facility Services	**10% after Deductible**	**30% after Deductible**

Prior Authorization is required for coverage of certain Covered Services. See the *Utilization Management* section for a list of these services and details on how to obtain Prior Authorization.

Physician and Related Services (Except Preventive Care)

Covered Services Include the following when provided, requested, or directed by Providers:

1. Services rendered or ordered by Physicians at a Hospital, including surgery; anesthesiology; radiology; pathology; and consultation with and treatment by consulting Physicians.

2. Services at a Physician's office or clinic facilities as provided or directed by the Member's Physician. These Include: medical and surgical treatment; professional administration of covered drugs, medicines, and medical supplies; and consultation with and treatment by other Physicians at their offices or other places as directed by the Member's Physician.

Inpatient Hospital Services (Non-Emergency)

The number of Hospital, Skilled Nursing Facility and home health days covered per Confinement is indicated in each specific subsection of this schedule of benefits.

Covered Services Include the following when provided, requested, or directed by Providers; room, board, and general nursing services in semi-private accommodations (private room only when Medically Necessary) and Hospital ancillary services Including the following: operating room and related facilities; delivery room; nursery; intensive care; cardiac care; neonatal care; diagnostic imaging; laboratory and other diagnostic tests; anesthesia; oxygen; special duty nursing when medically necessary; inpatient drugs (drugs prescribed at the time of dismissal for outpatient use are subject to the outpatient Prescription Drug Copayment); medicines, biological and medical supplies for in-hospital use; physical therapy; inhalation therapy; occupational therapy; speech therapy; chemotherapy; in-

hospital use of medical equipment; renal dialysis; Member education; administration of blood and blood components.

Outpatient Hospital, Ambulatory Care, Surgical Facility or Clinical Services

Outpatient use of an Institutional Healthcare Provider operating room with Medically Necessary ancillary services and supplies required during use of such room is covered subject to the *Exclusions* section.

For this purpose "surgery" means any cutting or invasive procedure for which the Hospital or other Institutional Healthcare Provider makes a specific operating room or procedure room charge.

If a Member is admitted directly to inpatient status from outpatient surgery at an Institutional Healthcare Provider, the outpatient surgery Copayment will be waived.

Outpatient surgery services performed at an Institutional Healthcare Provider other than a Hospital with Medically Necessary ancillary services and supplies required during the provision of such services are covered.

Other Outpatient Hospital and Clinical Services

Includes: physical, occupational, respiratory, and speech therapy, inhalation therapy; diagnostic X-rays and laboratory tests; radiation therapy; chemotherapy; professional administration of covered drugs (excluding medications dispensed by a Hospital for use after dismissal which are subject to a Coinsurance); Member education; renal dialysis; and pathology.

Covered Services, Whether Performed In or Out of the Hospital:

- Charges for mastectomy-related services, including (in compliance with the Women's Health and Cancer Rights Act) all stages of reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the opposite breast to produce a symmetrical appearance, prostheses; and treatment of physical complications of all stages of mastectomy, including lymphedemas; including mastopexy, reduction, or augmentation, reconstruction of the nipple and areola or tattooing of the areola area, breast prostheses up to two (2) external breast prosthesis, and two (2) bras per year (bathing suits are not covered), and complications of all stages of breast reconstruction (Including lymphedemas), up to limits in the *Schedule of Benefits* for Rehabilitative Therapy.
- Reconstructive surgery (other than reconstructive breast surgery, mastectomy and other breast procedures) is limited to surgery to improve or repair a body part only if it impairs function *and* is the result of, or incidental to, an initial surgery/Injury/Illness on that body part.
- Reconstructive surgery for the treatment of a medically diagnosed congenital disease or anomaly that requires Medically Necessary treatment (other than an oral or dental defect).
- Reconstructive surgery for the treatment of a congenital disease or anomaly that does not impose a functional impairment, but results in the absence of a body part is a Covered Service. A functional defect is one that interferes with a Member's ability to perform activities of daily living, as determined by the Plan. Examples Include coverage for cleft lip, nasal deformities, breast

reconstruction for Poland's Syndrome (congenital absence of the breast), and microtia repair (congenital absence of the ear).

- Surgical correction of scars causing a functional deformity is covered. Examples Include ectropion, joint contracture, and reconstruction of severe burn scars of the face and hands. Treatment of keloid scars is covered. The Plan does not cover otoplasty (correction for prominent ears), removal of non-malignant birthmarks (port wine stains, café-au-lait) or other non-malignant skin lesions (except when on the face, neck, or upper extremities of children), scar revisions, bifid ear lobes from pierced ears, or treatment of acne scarring.
- The Plan does not cover breast reconstruction to correct breast asymmetry except (1) for Poland's Syndrome (congenital absence of the breast and chest wall muscle), (2) in conjunction with surgical correction of the chest deformity, or (3) in repair of breast asymmetry due to a mastectomy.
- The Plan does not cover removal, replacement, revision or treatment of complications of silicone or saline breast implants placed for cosmetic reasons except as related to reconstruction after mastectomy. This Includes treatment of capsule formation, capsulectomy (removal of the firm scar tissue surrounding the breast implant), capsulotomy (incision of firm scar tissue surrounding the breast implant), capulorraphy (correction or improvement of implant position), mastopexy (breast lift), and treatment/removal of ruptured breast implants.
- The Plan does not cover surgery for correction of gynecomastia (mastectomy or liposuction), either unilateral or bilateral.
- Coverage for reduction mammoplasty surgery (breast reduction) is limited. Breast reduction surgery is not covered to correct macromastia unless both signs and symptoms of macromastia are present. Conditions that may contribute to symptomatic macromastia should be corrected prior to surgery, Including a body mass index in excess of thirty-five (35).

  Additional criteria:

  a. Proposed surgery must remove a minimum of 500 gms of actual breast tissue per breast (does not include tumescent fluid).

  b. Those Members proposed for breast reduction surgery age forty (40) and over must have had a negative mammogram within six (6) months of the surgical procedure.

- A Member receiving coverage for a mastectomy who elects breast reconstruction after the mastectomy, will receive coverage for:

  a. Reconstruction of the breast on which the mastectomy has been performed;

  b. Surgery and reconstruction of the other breast to produce a symmetrical appearance;

  c. Breast prostheses; and,

  d. Treatment of physical complications of all stages of the mastectomy, including lymphedemas.

  Coverage will be provided in consultation with the attending Physician and the Member, and will be subject to the same Cost-Sharing Amounts requirements that apply for the mastectomy.

  Axillary fat or axillary fat roll is not part of the breast, therefore removal, surgical or otherwise, is not covered.

- Medical treatment, surgery, or hospitalization for weight reduction and obesity are not typically covered. This exclusion will not apply to medical treatment or surgery for excess weight or obesity that results in the dysfunction of a body organ and causes life threatening health problems as defined below which cannot be treated effectively by another modality.
- In order to be considered for weight reduction surgery, a Member must be twenty-one (21) years old, have a Body Mass Index (BMI) of at least thirty-five (35), and have stabilized their weight within ten (10) pounds during the six (6) months prior to the procedure. In addition, the Member must have at least one of the following:

    1. Diabetes mellitus type one or two
    2. Documented uncontrolled hypertension with medication
    3. Documented uncontrolled hyperlipidemia with medication
    4. Steatohepatitis
    5. Documented coronary heart disease
    6. Sleep Apnea

    OR

    The Member must be twenty-one (21) years old, have a Body Mass Index (BMI) of at least forty (40), and have stabilized their weight within ten (10) pounds during the twelve (12) months prior to the procedure. In addition, the Member must be at high risk for obesity-associated morbidity and mortality.

- Resection of redundant tissue of skin (abdomen and thighs) following massive weight loss is considered reconstructive when performed to relieve specific clinical signs and symptoms. These services are covered when ALL of the following criteria are met:

    A. Member has a minimum Body Mass Index (BMI) of twenty-seven (27) after massive weight loss (BMI greater than [40]) and has maintained a steady weight for one (1) year, AND

    B. Documentation by the Member's surgeon demonstrating the following signs or symptoms listed for each procedure:

    <u>Abdominal Panniculectomy:</u>

    Severe skin ulcers, stage III -IV
    Symptoms and signs present of a minimum of one year
    Documentation of failure to respond to conservative therapy
    (Belt lipectomy or total body lift is non-covered)

    <u>Mastopexy</u>
    Non-covered (see Section VII)

    <u>Brachioplasty</u>
    Non-covered (see Section VII)

    <u>Medial thigh lift (lateral thigh lift is non-covered)</u>

Severe skin ulceration, stage III-IV
Symptoms and signs present for one (1) year
Documentation of failure to respond to conservative therapy

AND

C. Documentation and photographs must be provided to substantiate the resection of skin and fat redundancy following massive weight loss.

D. Documentation provided by the surgeon from the history or physical exam confirms the probability of significant relief of the clinical signs and symptoms. Photographs to document pre-operative conditions.

Genetic Testing.

The Plan covers genetic testing to establish a molecular diagnosis of an inheritable disease when all of the following are met:

A. The Member displays clinical features, or is at direct risk of inheriting the mutation in question (presymptomatic)*; AND

B. The result of the test will directly impact the treatment being delivered to the Member; AND

C. After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain, and one of the following diagnoses is suspected (this list is not all-inclusive): *

Fragile X Syndrome, Huntington's Disease, Cystic Fibrosis, Friedreich's ataxia, Familial Adenomatous Polyposis Coli, Spinal Muscular Atrophy, Duchenne Muscular Dystrophy, Myotonic Dystrophy, Prader-Willi Syndrome, Angelman Syndrome, Neurofibromatosis Type 1, Canavan disease, Hemochromatosis, Hemoglobin S and/or C **, Kennedy disease (SBMA), Charcot-Marie-Tooth, Medullary Thyroid Carcinoma, Classical Lissencephaly, Dentatorubral-pallidoluysian atrophy, Gaucher Disease, Neimann-Pick disease, Tay-Sachs, Von Hippel-Lindau syndrome, Retinoblastoma, Hemoglobin E thalassemia, Beta thalassemia**, Alpha thalassemia,** Albinism, Factor V Leiden mutation, Prothrombin 20210A mutation, Hereditary Neuropathy with Liability to Pressure Palsies (HNPP)

*When genetic tests are used to screen patients without signs or symptoms of disease, genetic tests are considered high-risk screening tests and are covered only for Members with preventive services benefits. By contrast, when genetic tests are used to diagnose patients displaying signs or symptoms of disease, they are considered diagnostic tests and are covered.

** Electrophoresis is the appropriate initial laboratory test for individuals judged to be at-risk for a hemoglobin disorder.

In the absence of specific information regarding advances in the knowledge of mutation characteristics for a particular disorder, the current literature indicates that genetic tests for inherited disease need only be conducted once per lifetime of the Member.

Note: Genetic testing Members is excluded from coverage if the testing performed is primarily for the medical management of other family members who are not covered under the Plan. In these circumstances, the insurance carrier for the family members who are not covered under this Plan should

be contacted regarding coverage of genetic testing. Occasionally, genetic testing of tissue samples from other family members who are not covered may be required to provide the medical information necessary for the proper medical care of a Plan Member. The Plan covers genetic testing for heritable disorders in non-Members when ALL of the following conditions are met:

D. The information is needed to adequately assess risk in the Member; and

E. The information will be used in the immediate care plan of the Member; and

F. The non-Member's benefit plan, if any, will not cover the test (a copy of the denial letter* from the non-Member's benefit plan must be provided). *The Plan may also request a copy of the certificate of coverage from the non-Member's health insurance plan if:

(i) the denial letter from the non-Member's insurance carrier fails to specify the basis for noncoverage or

(ii) the denial is based on a specific plan exclusion; or

(iii) the genetic test is denied by the non-Member's insurance carrier as not Medically Necessary and the medical information provided to the Plan does not make clear why testing would not be of significant medical benefit to the non-Member.

Varicose Vein Treatment.

The Plan covers varicose vein excision, ligation, sclerotherapy, and ambulatory phlebectomy when the saphenous varicosities result in any of the following:

- Intractable ulceration secondary to venous stasis; or
- More than one episode of minor hemorrhage from a ruptured superficial varicosity; or
- A single significant hemorrhage from a ruptured superficial varicosity, especially if transfusion of blood is required.

The Plan also covers varicose vein excision, ligation, sclerotherapy, and ambulatory phlebectomy after an unsuccessful trial of conservative management (e.g., compression stockings) through a minimum of three (3) months when the saphenous varicosities result in any of the following:

- Recurrent superficial thrombophlebitis; or
- Severe and persistent pain and swelling interfering with activities of daily living and requiring chronic analgesic medication for at least three (3) months

The results of Doppler studies should be submitted with requests for coverage of varicose vein treatment.

The Plan does not cover radiofrequency endovenous occlusion (VNUS procedure), photothermal sclerosis (also referred to as an intense pulsed light source), or endovenous laser ablation of the saphenous vein (ELAS)

Sclerotherapy

Sclerotherapy, with or without ultrasound guidance, is not covered for treatment of the saphenofemoral junction or the saphenous veins because sclerotherapy has been shown to be ineffective for treatment of these large veins. Sclerotherapy is covered when criteria are met for treatment of small to medium sized veins (< 6-mm diameter). Sclerotherapy alone has been shown to be ineffective and is not covered for patients with reflux at the saphenofemoral or saphenopopliteal junctions; under established guidelines,

patients with reflux should also be treated with ligation or division of the junction to reduce the risk of varicose vein recurrence.

The number of sclerotherapy injection sessions varies with the number of anatomical areas that have to be injected, as well as the response to each injection. It usually takes one (1) to three (3) injections to obliterate any vessel, and ten (10) to forty (40) vessels, or up to twenty (20) injections in each leg, may be treated in any one session. Initially, up to three (3) sclerotherapy sessions for both legs are covered for patients who meet patient selection criteria. Requests for additional sclerotherapy sessions for both legs should be submitted for medical review to determine whether additional sclerotherapy is covered using the above criteria.

In addition to Cost Sharing Amounts, the Member will also be responsible for any charges above Usual and Customary Rates when receiving Covered Services Out-of-Network.

(j) MATERNITY

Service	In-Network cost to Member	Out-of-Network cost to Member
Office Visits	**$15 Copayment first prenatal visit only**	**30% after Deductible**
Delivery	**10% after Deductible**	**30% after Deductible**

Prior Authorization is required for coverage of certain Covered Services. See the *Utilization Management* section for a list of these services and details on how to obtain Prior Authorization. Note: for pregnant women, precertification is required only for hospital stays that last or are expected to last longer than 48 hours for a vaginal delivery and 96 hours for a C-section. *(compliance with Newborn's act)*

Maternity services Include prenatal exams and tests, delivery, perinatal services, and postnatal care.

The Plan, in compliance with the Newborns' and Mothers' Health Protection Act, shall not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or the newborn child to less than forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a cesarean section. However, the plan may pay for a shorter stay if the attending provider (physician, nurse midwife or physician assistant) discharges the mother or newborn earlier, after consulting with the mother.

Except in the case of an Emergency, inpatient maternity services are only covered if provided in a Hospital and authorized or arranged by the Member's physician or obstetrician before or during Confinement. The authorization shall not be used to require the Member's physician or obstetrician to prescribe the minimum length of stay required by this section.

For the time period during which a female Member is receiving maternity services from an obstetrician, the obstetrician may refer the Member to other outpatient specialty services covered under this Plan. Such specialty, including obstetrical services through a perinatologist, and ancillary services are subject to the applicable Copayment or Coinsurance.

In addition to Cost Sharing Amounts, the Member will also be responsible for any charges above Usual and Customary Rates when receiving Covered Services Out-of-Network.

(k) MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES

Service	CIGNA Behavioral Health Provider	Non-CIGNA Behavioral Health Provider
Mental Health – Outpatient	**$10 copay, unlimited visits through CIGNA Behavioral Health providers**	**10% after deductible, non-CIGNA Behavioral Health providers**
Mental Health - Inpatient	**No Benefit**	**$150 copay per admission and 20% of billed charges**
Chemical Dependency – Outpatient	**$10 copay, unlimited visits through CIGNA Behavioral providers**	**10% after deductible, non-CIGNA Behavioral Health providers**
Chemical Dependency - Inpatient	**No Benefit**	**$150 copay per admission and 20% of billed charges**

Prior Authorization is required for coverage of Inpatient Services. See the *Utilization Management* section for a list of these services and details on how to obtain Prior Authorization.

A Member may self-refer to Providers specified for mental health services.

1. Coverage includes unlimited outpatient treatment visits

   Included in the outpatient treatment visits are all outpatient diagnoses and treatment of mental or nervous disorders except those specifically listed. Non-CIGNA Behavioral Health group treatment sessions are provided at a ratio of no less than two (2) group treatment hours to one (1) individual treatment hour. Non CIGNA Behavioral Health services include individual and group therapy.

2. Other Covered Services Include outpatient psychological testing and Prescription Drug medication management services.

3. Coverage for alcoholism and chemical dependency services is for up to thirty (30) days per Confinement. Maximum of 2 Confinements per lifetime.

Inpatient services covered under this section include semi-private care in an Institutional Healthcare Provider. Any cost difference between a semi-private and a private room is covered by the Plan only if a private room is Medically Necessary.

In addition to Cost Sharing Amounts, the Member will also be responsible for any charges above Usual and Customary Rates when receiving mental health and chemical dependency outpatient Covered Services Out-of-Network.

(l) OUTPATIENT PRESCRIPTION DRUGS (Retail and Mail Order)

Service	In-Network cost to Member	Out-of-Network cost to Member
Retail Generic	**10% Coinsurance Minimum-$10, Maximum - $20**	**50%**
Retail Brand	**20% Coinsurance Minimum - $20, Maximum - $40**	**50%**
Retail Non-formulary	**40% Coinsurance Minimum - $40, Maximum - $80**	**50%**
Mail Order (90 day supply) Generic	**$20**	**No Benefit**
Mail Order Brand and Non-Formulary	**$50 Brand / $100 Non-Formulary**	**No Benefit**

Prior Authorization is required for coverage of certain Covered Services. See the *Utilization Management* section for a list of these services and details on how to obtain Prior Authorization.

Prescription Drugs and medicines prescribed by a Healthcare Provider, for services covered by this Plan, when received at a Pharmacy, will be covered; provided, however, that only drugs and medicines for which a Physician's prescription is required by law, and those which contain a Prescription Drug and must be compounded by a pharmacist to a Physician's order are covered, except as indicated in this Section. Prescription Drugs are subject to the applicable Coinsurance.

1. The Maximum Amount of a drug covered for any one prescription or refill is a thirty-four (34) day supply. Up to three (3) thirty-four (34) day supplies may be dispensed at one (1) time and covered by the Plan, provided that the Coinsurance is paid for each thirty-four (34) day supply received. The Plan reserves the right to determine what constitutes a thirty-four (34) day supply of a medication. One example is the thirty-four (34) day supply definition for sumatriptan (Imitrex) products: eighteen (18) tablets, four (4) injections, or twelve (12) nasal sprays. Up to three (3) cycles of oral contraceptives may be dispensed at once and covered by the Plan for the applicable Coinsurance.

2. The non-Formulary drug Coinsurance will apply to non-Formulary Prescription Drugs that are not on the MMSI Formulary.

3. Infertility medications are not covered by the Plan.

4. Prescription Drugs may be obtained from the designated mail order Pharmacy. Once enrolled in the mail order program, medications are mailed directly to the Member's home or office. Mail order services are available for Members taking oral maintenance medications for such chronic conditions as high blood pressure, asthma, diabetes or depression. Members can receive up to a ninety (90) day supply of Prescription Drugs at a time for the appropriate Copayment.

5. Human growth hormone may be approved only for the treatment of short stature in growth hormone deficient children. This drug must be Prior Authorized through the Plan non-Formulary exception process.

6. Insulin needles/syringes and/or diabetic testing supplies do not require a corresponding insulin prescription. If a prescription exists with the same date of fill, no Coinsurance will be taken for needles/syringes and diabetic testing supplies. If no corresponding prescription exists, a separate Coinsurance will be taken for needles/syringes and/or diabetic testing supplies. The amount of the Coinsurance is based on the insulin prescribed and the corresponding designation on the Maximum Allowable Cost list. Prescribed oral agents for controlling blood sugar that are included on the Formulary.

7. Approved Injectable Prescription Drugs prescribed to be self-administered are limited to a thirty-four (34) day supply. Up to three (3) thirty-four (34) day supplies may be authorized by the Plan at one time, but each thirty-four (34) day supply requires the applicable Coinsurance.

8. Approved Injectable Prescription Drugs are covered and require no Coinsurance when administered in the following circumstances:

    a. When the medication is administered during an outpatient visit to a Physician (included as part of a Physician office visit Copay or Coinsurance),

    b. When the medication is provided as part of an approved home health program protocol,

    c. When the medication is provided as part of an approved home Hospice program protocol.

9. Approved Injectable Prescription Formulary drugs prescribed to be self-administered in settings or a manner other than those described above require Prior Authorization and are limited to a thirty-four (34) day supply. Up to three (3) thirty-four (34) day supplies may be authorized by the Plan at one time, but each thirty-four (34) day supply requires a Coinsurance.

Medicare Part D and your Prescription Drug plan:

If you and/or your dependent(s) are enrolled in either Part A or B of Medicare, you are also eligible for Medicare Part D Prescription Drug benefits. It has been determined that the prescription drug coverage outlined in this document is "creditable." "Creditable" means that the value of this Plan's prescription drug benefit is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.

Because this Plan's prescription drug coverage is as good as Medicare, you do not need to enroll in a Medicare Prescription Drug Plan in order to avoid a late penalty under Medicare. You may, in the future, enroll in a Medicare Prescription Drug Plan during Medicare's annual enrollment period (November 15 through December 31 of each year).

Medical Foods for Inherited Metabolic Disorders

Subject to the Copayment or Coinsurance, the cost of medical foods (modified low protein foods and metabolic formulas as defined below) as prescribed by a Physician to treat inherited metabolic disorders. "Cost" is defined as either billed charges if the Member purchased the medical foods directly, or the Plan's negotiated amount if the Member purchased them through a participating health care provider.

Medical food benefits are available for inherited metabolic disorders specified in the newborn screening program prescribed by Arizona law, Including: Phenylketonuria (PKU), Maple Sugar Urine Disease, Homocystinuria and Galactosemia. For any condition not included in the newborn screening program, Including lactose intolerance without a diagnosis of Galactosemia, medical food benefits are excluded.

The Plan does NOT cover oral nutritional support when the Member has a normal functioning gastrointestinal tract.

The Plan does NOT cover baby food or other regular food products including those that are blended and used in tube feeding systems.

Enteral Tube Feedings

The Plan covers tube feeding when the Member has a permanent* impairment involving the gastrointestinal tract that prevents adequate oral nutritional intake to maintain weight and strength.

*NOTE: If the judgment of the attending Physician, substantiated in the medical record, is that the impairment can reasonably be expected to exceed three (3) months (ninety (90) days), the test of permanence is considered met.

If the claim involves a pump, it must be supported by sufficient medical documentation, i.e., gravity feeding is not satisfactory due to aspiration, diarrhea, and dumping syndrome.

Infant Formula

Standard infant formulas are covered if administered via the tube-feeding route and the criteria for coverage of tube feedings are met.

Calorically dense formulas are also covered for tube feedings if they are indicated.

To be eligible for coverage for medical foods, ALL of the following criteria must be met:

a. the Member must be diagnosed with one of the inherited metabolic disorders as defined above;
b. the inherited metabolic disorder must involve amino acid, carbohydrate or fat metabolism and have medically standard methods of diagnosis, treatment and monitoring, including qualification of metabolites in blood, urine, or spinal fluid, or enzyme or DNA confirmation in tissues;
c. the Member must require specially processed or treated medical foods generally available only under the supervision of an In-Network Physician;
d. the medical foods must be prescribed or ordered under the supervision of a Physician for the therapeutic treatment of one of the inherited metabolic disorders identified above; and
e. the prescribed/ordered specially processed or treated medical foods must be consumed throughout life, without which, the Member may suffer serious mental or physical impairment.

It may be necessary for the Plan to obtain medical record documentation to determine the above criteria are met.

For this section only the following terms are defined as:

"Medical foods" - modified low protein foods and metabolic formulas. Each of these terms are defined as follows:

"Modified low protein foods" - foods that are ALL of the following:

- formulated to be consumed or administered through the gastrointestinal tract under the supervision of a Physician;
- processed or formulated to contain less than one (1) gram of protein per unit of serving;
- administered for the medical and nutritional management of a Member with limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation; and
- essential to the Member's optimal growth, health and metabolic homeostasis.

"Metabolic formula" - foods that are ALL of the following:

- formulated to be consumed or administered through the gastrointestinal tract under the supervision of an In-Network Physician;
- processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs;
- administered for the medical and nutritional management of a Member with limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation; and
- essential to the Member's optimal growth, health and metabolic homeostasis.

Coverage is not available for any of the following:

- medical foods for any medical condition other than those inherited metabolic disorders as defined above;
- natural foods that are naturally low in protein and/or galactose;
- spices/flavorings;
- foods/formulas available to any person, even a person with an inherited metabolic disorder as defined above, that may be purchased without an In-Network Physician prescription/order and/or that do not require supervision by an In-Network Physician.

To receive coverage the Member must purchase medical foods (as defined above) from an In-Network Healthcare Provider.

Botulinum Toxin

The Plan covers botulinum toxin type A (Botox®) for any of the following conditions:

a. Strabismus, Including neuromyelitis optic and Schilder's disease. Strabismus repair is not covered in adult patients with uncorrected congenital strabismus and no binocular fusion, as this is considered cosmetic.
b. Blepharopspasm
c. Hemifacial spasm/post-facial nerve palsy synkinesis
d. Laryngeal spasm
e. Focal dystonias, Including cervical dystonia (spasmodic torticollis), lingual dystonia, laryngeal dystonia, jaw-closing oromandibular dystonia, hand dystonia (organic writers cramp), symptomatic torsion dystonia
f. Limb spasticity, Including spastic paraplegia, limb spasticity due to multiple sclerosis, spastic hemiplegia, and infantile cerebral palsy
g. Esophageal achalasia, for patients who have at least one of the following:
    - Have failed conventional therapy;
    - Are at high risk of complications of pneumatic dilation or surgical myotomy;
    - Have failed a prior myotomy or dilatation;
    - Have had a previous dilation-inducted perforation; OR
    - Have an epiphrenic diverticulum or hiatal hernia, both of which increase the risk of dilation-inducted perforation.
h. Chronic anal fissure unresponsive to conservative therapeutic measures
i. Focal hyperhydrosis, when all of the following criteria are met:
    - Topical aluminum chloride or other extra-strength antiperspirants are ineffective or result in a severe rash; AND
    - Member is unresponsive or unable to tolerate pharmacotherapy prescribed for excessive sweating; AND
    - Significant disruption of professional and/or social life has occurred because of excessive sweating.
j. Ptyalism (excessive secretion of saliva) that is refractory to pharmacotherapy
k. Facial myokymia and trismus associated with postradiation myokymia
l. Non-relaxing pubococygeal syndrome (inability to defecate) unresponsive to biofeedback

Botulinum type B (Myobloc®) is covered for symptomatic treatment of Members with cervical dystonia (spasmodic torticollis) only.

The Plan does not cover botulinum toxin (A or B) for any of the following conditions.

- Headache, Including migraine or tension headache
- Facial wrinkles
- Neck or lip wrinkles
- Painful cramps
- Blepharoplasty or brow lift
- Bell's palsy
- Urinary and anal sphincter dysfunction
- Fibromyositis
- Stuttering
- Irritable colon
- Biliary dyskinesia
- Temporomandibular joint (TMJ) disorders

- Pectoralis muscle contraction in breast surgery/augmentation

(m) PREVENTIVE CARE

Service	In-Network cost to Member	Out-of-Network cost to Member
Routine Physicals / Wellness Exams	**$15 Copayment per visit**	**30% after Deductible**
Gynecological Screening Exam & General Gynecological Services	**$15 Copayment per visit**	**30% after Deductible**
Mammography Screening Exam	**$15 Copayment per visit**	**30% after Deductible**
Well Child Care	**$15 Copayment per visit**	**30% after Deductible**
Immunizations/ Allergy Injections	**$0 Copayment per visit**	**$0 Copayment per visit**

Preventive Covered Services Include:

a. **Routine Preventive Exams** (Including Routine Gynecological Exams and Well-Child Care). The Member's Physician will determine the medically appropriate frequency of preventive examinations and health screening procedures, based on relevant factors such as age, sex, health status, and risk factors. Women Members may see a gynecologist for one (1) routine gynecological exam per twelve (12) month period. Well-child care exams include pediatric preventive services, appropriate immunizations, developmental assessments, and laboratory services.

b. **Health Education**. Includes courses offered by the Plan or its personnel, on the order of the Member's Physician, as appropriate to the Member's medical condition. Covered educational services are limited to those directly related to the Member's medical condition, in the opinion of the Member's Physician or the Plan. However the Plan may from time to time publish lists of medical education courses and programs covered when ordered by a Physician.

c. Procedures and materials for immunization of children and adults in accord with currently accepted medical practice.

A Member may receive mammography screenings performed on dedicated equipment for diagnostic purposes according to the discretion of her Physician.

Vision Screening. The Plan covers one in-network (1) routine vision screening exam to find the refractive error of the eye per twelve (12) month period for each Member two (2) years of age and older. For a Member between the age of birth and twenty-four (24) months, the Plan covers one (1) vision screening exam every four (4) months. A Member may self-refer to either an optometrist or ophthalmologist for these services. There is a $10 Copayment per visit.

Eyeglass fittings, or the adjustment of eyeglasses, and/or repair of such materials, are not covered under this Plan. In addition, radial keratotomy (RK), photo refractive keratotomy (PRK), and other vision correction surgical procedures are not covered. Materials discounts are available through Vision Service Plan (VSP)

Audiology Services. The Plan covers in-network hearing screening tests provided by a Healthcare Provider and subject to a $10 copayment.

Hearings aids, fitting, adjustment, or repair of such items, are not covered.

In addition to Cost Sharing Amounts, the Member will also be responsible for any charges above Usual and Customary Rates when receiving Covered Services Out-of-Network.

(n) REHABILITATION SERVICES

Service	In-Network cost to Member	Out-of-Network cost to Member
Physical, Occupational, Speech, Rehabilitation, & Respiratory Services	**10% after Deductible**	**30% after Deductible**

Prior Authorization is required for coverage of certain Covered Services. See the *Utilization Management* section for a list of these services and details on how to obtain Prior Authorization.

Physical and occupational therapy on an inpatient basis is covered. Outpatient coverage is limited. Coverage for physical, occupational, and speech and respiratory therapy services is limited to sixty (60) visits per Coverage Year for any combination of OT, PT or speech therapy. .

Treatment for speech therapy and respiratory therapy on an inpatient basis is covered. Coverage on an outpatient basis is limited to those services, which in the judgment of the Plan, can be expected to bring significant improvement. Treatment for tongue thrust is not covered.

Treatment for learning disabilities is limited in scope. Coverage is provided only for those learning disabilities acquired through injury or illness, and is limited to the services outlined in the previous paragraph.

Phase I cardiac rehabilitation is a covered benefit. Phase II cardiac rehabilitation is covered only for those Members who have:

a. A documented arrhythmia of clinical significance during Phase I cardiac rehabilitation or during an exercise treadmill after Phase I cardiac rehabilitation; or

b. Evidence of ongoing significant ischemia as documented during Phase I cardiac rehabilitation or during an exercise treadmill after Phase I cardiac rehabilitation.

Those Members ineligible for Phase II cardiac rehabilitation are covered for up to five (5) Rehabilitation visits for the development of a home exercise program and follow-up.

In addition to Cost Sharing Amounts, the Member will also be responsible for any charges above Usual and Customary Rates when receiving Covered Services Out-of-Network.

(o) SKILLED NURSING AND REHABILITATION FACILITIES

Service	In-Network cost to Member	Out-of-Network cost to Member
Skilled Nursing Facility or Rehabilitation Facility	**10% after Deductible**	**30% after deductible**

Prior Authorization is required for coverage of certain Covered Services. See the *Utilization Management* section for a list of these services and details on how to obtain Prior Authorization.

There is a 60-day maximum per Member per Coverage Year for Skilled Nursing and Rehabilitation Facilities. .

Coverage includes skilled nursing and therapeutic services; but only for Short-Term convalescence. Physical, occupational, respiratory and speech therapy are covered subject to certain limitations, see the *Rehabilitation Services* subsection of this *Schedule of Benefits* section.

Any difference between semi-private and private room costs will not be covered by the Plan unless the private room is required for contagion or immunosuppression reasons.

The maximum number of Rehabilitation Facility days covered per Coverage Year is shown above. Coverage Includes Rehabilitation, skilled nursing and therapeutic services; but only for Short-Term convalescence. Physical, occupational, respiratory and speech therapy are covered subject to certain limitations, see the *Rehabilitation Services* subsection of this *Schedule of Benefits* section.

In addition to Cost Sharing Amounts, the Member will also be responsible for any charges above Usual and Customary Rates when receiving Covered Services Out-of-Network.

(p) TRANSPLANTS

Service	In-Network cost to Member	Out-of-Network cost to Member
Transplants – hospitalization	**10% after Deductible**	**30% after Deductible**
Transplants – associated office visits	**10% after Deductible**	**30% after Deductible**

Prior Authorization is required for coverage of certain Covered Services. See the *Utilization Management* section for a list of these services and details on how to obtain Prior Authorization.

Coverage is provided only for Covered Services directly related to transplantation of human bone marrow/stem cells, cornea, kidney, liver, heart/lung, heart, lung and pancreas transplants, Including:

a. Institutional Healthcare Provider and professional services for organ transplantation;
b. FDA approved drugs;
c. Medically Necessary equipment and supplies;
d. Two round trip "coach" air transportation charges for the Member and one (1) family member or companion, to and from the approved transplant facility for each required visit approved by the Plan. The plan benefit payable for air transportation, lodging and meals combined is $10,000 per transplant;
e. Lodging and meals, outside the Service Area, for two (2) people as Prior Authorized by the Plan. Maximum reimbursement for lodging is $150. Receipts are required when submitting meals, lodging and transportation expenses for payment consideration. The plan benefit payable for air transportation, lodging and meals combined is $10,000 per transplant;
f. Organ or tissue procurement and acquisition fees, Including surgery, storage, and organ or tissue transport costs directly related to a living or non-living donor;
g. Reasonable and necessary healthcare expenses incurred by a donor who is covered by the Plan, without any Coinsurance applicable to those expenses; or
h. Reasonable and necessary healthcare expenses incurred by a donor who is not covered by the Plan, without any Coinsurance applicable to those expenses, but only to the extent the expenses of the donor are not covered by the donor's own insurance or healthcare plan.

In addition to Cost Sharing Amounts, the Member will also be responsible for any charges above Usual and Customary Rates when receiving Covered Services Out-of-Network.

SECTION VII

EXCLUSIONS

7.1 **Exclusions**. Notwithstanding any provision in the Plan to the contrary, the Plan will not provide benefits for the following services, medical procedures or supplies, regardless of Medical Necessity or recommendation by a Healthcare Provider. The Member is responsible for 100% of the expenses associated with the listed exclusions. These expenses are not Covered Services. In addition to those exclusions listed below, the *Schedule of Benefits* section contains additional exclusions.

No benefits are available for:

(1) **Acts of War.** Injury or Illness resulting from war or any act of war (declared or undeclared) is not covered.

(2) **Acupressure –** Acupressure treatments are not covered.

(3) **Acupuncture -** Acupuncture coverage is limited only to patients with chronic musculoskeletal problems that have failed conservative medical management (medications, physical therapy) may be referred to Mayo Clinic Physical Medicine and Rehabilitation for consideration of acupuncture treatment. If approved by the Medical Director, Subscribers have up to six (6) treatments available per year. There must be notable improvement after three (3) treatments to continue for the remaining three.

Discounted acupuncture and acupressure treatments are available outside the medical benefit using the Affinity Program through American Specialty Health (ASH). This program may be accessed through the ASH web site www.ashnetworks.com

(4) **Allergy Testing.** Skin titration (Rinkle method); Cytotoxicity testing (Bryan's test); RAST testing; Urine autoinjections; Provocative and Neutralization testing for allergies are not covered.

(5) **Augmentative Communication Devices.** Augmentative communication devices of any type are not covered.

(6) **Apnea Monitoring Devices.** Oral splint devices for obstructive sleep apnea are covered under the Plan's Durable Medical Equipment (DME) benefit. Apnea testing at an Institutional Healthcare Provider is covered subject to Prior Authorization. Laser assisted uvuloplasty (LAUP) and similar procedures for the treatment of snoring and/or sleep apnea are not covered. Surgery for the correction of sleep apnea is not covered unless the Member has failed the use of CPAP or BiPAP therapy. Adult and Infant apnea monitors are covered if Prior Authorized.

(7) **Birth Control Devices.** Coverage for implantable drug delivery devices for contraceptive therapy is limited to one (1) device and services for one (1) insertion and one (1) removal within a five (5) year period. Removal due to infection at the implantation site or due to medical complications as determined by a Physician is not

subject to the one (1) removal limit noted above. However, reinsertion following removal due to infection or medical complications is not covered by the Plan if such reinsertion occurs within five (5) years of the previous insertion.

(8) **Blepharoplasty and Other Procedures to Correct Lid Ptosis.** These procedures are not covered unless taped visual field testing demonstrates at least a twenty-degree improvement in vision compared to untaped visual field testing.

(9) **Blood.** Charges for autologous blood transfusions that are in excess of the charges for normal blood transfusions are not covered. Charges for freezing, thawing, or storing one's own blood or umbilical cord blood are not covered. Administration of blood is covered as provided in the *Inpatient and Outpatient Hospital and Physician Services* subsection of the *Schedule of Benefits* section.

(10) **Blood Pressure Monitoring Equipment.** Blood pressure monitoring equipment is not covered.

(11) **Breast Asymmetry Correction.** Not covered unless the asymmetry results in a significant medical problem as determined by the Plan, unless the services are in conjunction with breast reconstructive surgery following a mastectomy. If not due to a mastectomy, only reduction of the larger breast is covered if the individual meets the criteria outlined earlier in this document. Mastopexy or augmentation of the smaller breast is not covered.

(12) **Breast Implants.** The Plan does not cover removal, replacement, revision or treatment of complications of silicone or saline breast implants placed for cosmetic reasons except reconstruction after a mastectomy. This Includes treatment of capsule formation, capsulectomy (removal of the firm scar tissue surrounding the breast implant), capsulotomy (incision of firm scar tissue surrounding the breast implant), capulorraphy (correction or improvement of implant position), mastopexy (breast lift), and treatment/removal of ruptured breast implants.

(13) **Breast Pumps.** Breast pumps are not covered.

(14) **Breast Reduction Surgery.** Surgery to correct macromastia is not covered unless both signs and symptoms of macromastia are present. Members must have failed an effort at conservative management of their macromastia including efforts to improve or correct conditions that may be contributing to the macromastia before breast reduction surgery is a covered benefit. See also the criteria outlined earlier in this document.

(15) **Car Seats.** Car seats are not covered.

(16) **Certain Mental Health Services and Supplies.** Mental health services, supplies, and Prescription Drugs which are not covered: (1) for a mental illness not listed in the Diagnostic and Statistical Manual IV of the American Psychiatric Association; (2) beyond the time needed for evaluation and diagnosis of mental retardation; (3) for mental illnesses, which by accepted standards, are not amenable to improvement; (4) for marriage and family counseling, unless the requirements of the *Mental Health And Chemical Dependency Services* subsection of the *Schedule of Benefits* section are met

(17) **Certain Physical Examinations.** Any physical examination or evaluation or any mental health or substance abuse examination or evaluation given primarily: (1) at the request of; (2) for the protection or convenience of; or (3) to meet a requirement of third parties, including employers and insurers, is not covered, unless authorized by the Plan.

(18) **Chiropractic.** All chiropractic services except those specifically listed in the *Chiropractic Services* subsection of the *Schedule of Benefits* section, for example services for conditions other than those related to neuromusculoskeletal disorders from In-Network Chiropractors, and thermography are not Covered Services. Emergency and adjunctive therapy not associated with spinal, muscle or joint manipulation is not covered.

(19) **Cosmetic Surgery.** Surgery and associated services or supplies to improve or change appearance (other than reconstructive surgery that is specifically listed as a Covered Service in the *Schedule of Benefits* section) are not covered.

Examples of cosmetic surgery or procedures Include:

- Excision, excessive skin, abdomen, thigh, leg, hip, buttock, arm, forearm submental fat pad, or other areas
- Chemical peel for skin wrinkles
- CO2 laser skin resurfacing
- Salabrasion
- Chemical exfoliation for acne
- Grafts – fat, Gore-Tex, skin substitutes (Alloderm) and dermal/fat;
- Electrolysis, laser waxing, or depilatories for hirsutism
- Suction assisted lipectomy (liposuction) or variants of liposuction
- Correction of diastasis recti abdominis (abdominoplasty)
- Removal of spider angiomata
- Reduction of labia minora
- Surgery for facial rejuvenation
- Anti-aging treatment/evaluation, Including growth hormone replacement
- Collagen implants
- Dermabrasion for removal of acne scars or pox scars
- Botulinum toxin for the treatment of frown lines or wrinkles (please refer to Botulinum Toxin in the *Schedule of Benefits* section)
- Cosmetic breast augmentation and other cosmetic breast surgery

- Surgery to correct snoring
- Otoplasty
- Surgery to correct gynecomastia
- Repair of torn ear lobes
- Treatment of skin wrinkling
- Lentigenes
- Melasma
- Scar revision (please refer to the *Schedule of Benefits* section)
- Removal of skin tags
- Rhinoplasty (please refer to the *Schedule of Benefits* section)
- Nipple reduction
- Correction of inverted nipples
- Tattoo removal
- UV light treatment of vitiligo (tanning)

(20) Cosmetic surgery for psychiatric or psychological indications is not covered when no functional impairment is present.

(21) Surgical treatment of disfigurement from rosacea (e.g., telangiectasias, rhinophyma, and scarring) is cosmetic and is not covered. The Plan does cover medical treatment of rosacea.

(22) Surgical treatment of disfigurement from HIV and related treatment Including facial wasting and fat deposits on the back of the neck (cervical hump) is cosmetic and is not covered.

(23) Cosmetic supplies, Including bras (except post mastectomy bras), girdles, binders, silicone sheeting (except in the treatment of recurring Keloid scars), scar reduction products, and topical anesthetics related to the above cosmetic surgery procedures are not covered.

Complications from cosmetic procedures relating to the surgical body part treated are not covered by the Plan. Examples are post-operative bleeding, local infections after surgery, local skin loss after surgery, excess or unexpected scarring or disfigurement, and treatment of post-operative pain or surgical revisions. Other non-covered services Include laboratory services, pathology services, x-ray, facility, operating room, surgical supplies and garments relating to the cosmetic procedure or complications. Treatment of distant body or organ system complications related to cosmetic surgery are covered, such as DVT, pulmonary embolus, myocardial infarction, and sepsis, as well as Medically Necessary inpatient care.

(24) **Custodial or Domiciliary Care.** Services that are primarily Custodial or domiciliary are not covered. This Includes homemaker, home health aide, routine nursing home services, rest cures, and days in a Plan Skilled Nursing Facility that are not covered under the Skilled Nursing and Rehabilitation Facility subsection of the *Schedule of Benefits* section.

(25) **Dentistry.** General dental services are excluded Including: restoration; correction of malocclusion; osseointegration (i.e., dental implants) and similar procedures; orthognathic surgery; LeForte Procedure; surgical orthodontics; repair, restoration or extraction of erupted teeth or teeth impacted under soft tissue; dental X-rays; dental anesthesia or analgesia; orthodontics; hospitalization or analgesia for excluded dental services; cosmetic dental services Including splints, braces, jaw repositioning and dental restoration; any surgery to correct a congenital anomaly (except as expressly provided in the *Inpatient and Outpatient Hospital and Physician Services* subsection of the *Schedule of Benefits* section); and other professional or Hospital services or supplies for treatment of, or operation on, the teeth or periodontal tissue, are not covered except as expressly provided in the *Dental Services and Oral Surgery* subsection of the *Schedule of Benefits* section. Dental implants are not covered. Dental services Including orthodontia for the treatment of TMJ are not covered.

(26) **Experimental or Investigative.** Experimental or Investigative Healthcare Services, procedures, drugs, devices, services or supplies.

(27) **Government Responsibility.** Services that are excluded by federal, state, or local law, or any action of the federal, state or local government in reliance on such law are not covered.

(28) **Health Clubs.** Health club memberships and exercise programs at health clubs are not covered.

(29) **Infertility Treatment.** Services involving sperm acquisition and sperm storage charges; artificial insemination; reversal of surgical sterilization; treatment of infertility after reversal of sterilization; assisted reproduction Including but not limited to in vitro and in vivo fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), intracytoplasmic sperm injection (ICSI), use of donor egg, and experimental procedures; costs incurred by or for a non-Member surrogate's pregnancy (other than in the case of an adoption where all the requirements of Arizona Revised Statutes § 20-1057.K. and L. are met); and any related charges incurred for these excluded procedures are not covered.

Medications to treat infertility are not covered, including medications prescribed to prevent recurrent spontaneous abortions.

(30) **Mental Retardation or Defects and Deficiencies.** Services for treatment of mental retardation or defects and deficiencies of functional nervous disorders Including chronic mental illness are not covered.

(31) **Mayo Clinic Scottsdale Executive Health Exam Services.** The Mayo Clinic Scottsdale Executive health exam and all other executive health programs/exams are not covered under the physical exam benefit. Any charges for services related to the Mayo Clinic

Scottsdale Executive health exam and all other executive health programs/exams would be the responsibility of the Member.

(32) **Medicare Coverage Guidelines.** Services and supplies (1) not specifically addressed or described in the Plan, and (2) not addressed or described in Medicare guidelines.

(33) **Non-FDA Devices and Procedures.** Non-FDA devices and procedures are not covered unless addressed in the *Schedule of Benefits* section.

(34) **No-Show Charges.** If a Member fails to honor an appointment with a Healthcare Provider, except in the case of an Emergency, the Member may be charged a missed appointment fee by the Healthcare Provider for which the Plan shall not be liable.

(35) **Out-of-Network Healthcare Providers.** Services rendered by Out-of-Network Healthcare Providers are covered as addressed in the *Schedule of Benefits* section.

(36) **Not Medically Necessary.** Services or supplies that are not, in the judgment of Physicians or the Plan or its designee, necessary for medical treatment or for maintenance or improvement of the Member's health are not covered. Examples Include examinations for employment and licensing, research, school, camp, sports, or executive physicals. The exclusion of coverage in such cases is solely a benefit determination and not a medical treatment determination or recommendation.

(37) **Obesity.** Medical treatment, surgery, or hospitalization for weight reduction or obesity is not covered. This exclusion will not apply to medical treatment or surgery for excess weight or obesity that results in the dysfunction of a body organ and causes life threatening health problems that cannot be treated effectively by another modality, whether performed in or out of the Hospital.

(38) **Organ/Tissue Donor.** Services and supplies in connection with donation of an organ/tissue for transplant to anyone who is not a Member are not covered.

(39) **Organ/Tissue Transplants.** Transplants of the adrenal gland are not covered nor are all other organ/tissue transplants not specifically included in the *Schedule of Benefits* section. Non-human organ/tissue transplants are not covered.

(40) **Personal Comfort.** Television, television cable service, telephone, barber or beauty service, household fixtures and equipment, guest service and the like are not covered.

(41) **Prescription Drugs Not Covered through Pharmacies.** Nasal analgesics, appetite suppressants or weight loss medications, infertility treatments, drugs for cosmetic purposes, over-the-counter drugs (OTC), alternative (aka complimentary) medications such as homeopathic, naturopathic or herbal remedies, Investigational and Experimental medications, unapproved supplements, and non-FDA approved drugs are not covered, except as required by law.

(42) **Private Duty Nursing.** Private duty nursing is not covered.

(43) **Private Hospital Rooms.** Private hospital rooms are not covered unless Medically Necessary.

(44) **Prostheses and Equipment.** Prosthetic devices, medical equipment or appliances, and all supplies and services related to such non-covered devices including: air conditioners; exercise bicycles and exercise equipment; humidifiers; Ace bandages; support (Jobst) stockings gloves or sleeves; (except as provided for in Section VI.d.); wigs; breast prostheses (except as provided for in Section VI.d.); lift chairs; equipment to facilitate driving and/or transporting motor vehicle equipment for disabled Members; lift-toilets; and any other such materials not expressly provided for in the *Schedule of Benefits* section are not covered.

(45) **Related Provider.** Services of providers who live with the Member or are members of the Member's Family, except in the regular employment of the nurse by an In-Network Hospital, Skilled Nursing Facility, or other In-Network Institutional Healthcare Provider are not covered.

(46) **Reversal of Voluntary Sterilization.** Surgical reversal of voluntary sterilization for men or women is not covered.

(47) **Routine Foot Care.** Routine foot care Including corn and callous removal, nail trimming, and other hygienic or maintenance care; and cleaning, soaking and skin cream application for ambulatory and bed-confined patients are not covered.

(48) **Scalp Hair Prostheses.** Scalp hair prostheses (i.e., wigs) are not covered.

(49) **Self-Administered Supplies.** Disposable self-administered supplies are not covered, except as specifically described in the *Schedule of Benefits* section. Examples of such self-administered supplies Include: catheters, outpatient drugs and medicines which do not require a Physician's prescription; nutrition supplies and supplements; vitamins; and any other supplies or substances administered by the Member or a lay person and not by a Professional Healthcare Provider. Infant formula except as noted under Medical Foods in the Schedule of Benefits is not covered.

(50) **Sex Change.** Services and supplies for sex change; or for replacement of all or parts of sex organs, except for dysfunction due solely to organic disease or Injury are not covered.

(51) **Travel Expenses.** Travel or transportation even though prescribed by an In-Network Physician (except **Ambulance** services and transplant services as provided in the *Schedule of Benefits* section) are not covered.

(52) **Treatment in a Federal, State, or Governmental Entity.** To the extent allowed by applicable laws: coverage for care and treatment provided in an Out-of-Network Hospital owned or operated by any federal, state, or other governmental entity; and care of military service-connected conditions for which the Member is legally entitled to services and for which facilities are reasonably accessible to the Member are not covered.

(53) **Vision and Hearing Aids.** Purchase or fitting of eyeglasses, or other fabricated optical devices and purchase of contact lenses are not covered. Radial keratotomy (RK), LASIK, photo refractive keratotomy (PRK), and other vision correction surgical procedures are not covered. Purchase or fitting of hearing aids (whether external or implantable)

(54) **Weight Reduction Programs and Nutritional Counseling.** Weight reduction programs, food supplements, weight checks and ongoing nutritional or diet counseling are not covered. However, the Plan will cover an initial consultation to determine a medical care program for weight reduction.

SECTION VIII

CLAIMS PAYMENT AND APPEAL PROCEDURE

8.1 Introduction. All claims must be submitted to the Plan and all claims review will comply with the rules and procedures set forth in this *Claim and Appeal Procedures* section.

8.2 Definitions.

(a) Adverse Benefit Determination - a denial, reduction, or termination of a benefit, or a failure to provide or make payment (in whole or in part) for a benefit.

(b) Authorized Representative - a person designated by a Claimant or the Plan to act on behalf of a Claimant.

(c) Claimant - a person who believes he/she is entitled to benefits under the Plan. In this *Claim and Appeal Procedures* Section, the term Claimant shall also include a Claimant's Authorized Representative, if applicable

(d) Concurrent Care Claim - a claim that requires Prior Authorization under the Plan that is reconsidered after a course of treatment has been initially approved. There are two types of Concurrent Care Claim, (1) where a reconsideration by the Plan results in a reduction or termination of coverage for a previously approved benefit, and (2) where an extension is requested by the Claimant for coverage beyond the initially approved benefit.

(e) Post-Service Claim - any claim for a benefit under this Plan that is submitted for payment or reimbursement after the services have been rendered.

(f) Pre-Determination - a determination of coverage under the Plan, when Prior Authorization is not required, sought by a Member prior to services being rendered. A Pre-Determination is not a claim for benefits under the Plan.

(g) Pre-Service Claim - any claim for a benefit under this Plan where receipt of the benefit is specifically conditioned, in whole or in part, on receiving approval in advance of obtaining the medical care. Benefits under this Plan that are Pre-Service Claims (i.e., subject to approval in advance) are listed in the *Utilization Management* section as services that require Prior Authorization.

(h) Urgent Pre-Service Claim - an Urgent Pre-Service Claim is a type of Pre-Service Claim. An Urgent Pre-Service Claim is any claim for medical care or treatment with respect to which the application of the timeframes for making non-urgent determinations could seriously jeopardize the life or health of the Claimant or the Claimant's ability to regain maximum function, or – in the opinion of a Physician with knowledge of the Claimant's medical condition – would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If a Physician with knowledge of the Claimant's medical condition determines that a claim is an Urgent Pre-Service Claim, the claim will be treated as an Urgent Pre-Service Claim. A Physician may be required to complete an "Urgent Pre-Service Claim

Determination by Physician" form, if requested, in such cases.

8.3 Types of Claims.

(a) This Plan has four categories of claims as defined above.

(1) Concurrent Care Claim

(2) Post-Service Claim

(3) Pre-Service Claim

(4) Urgent Pre-Service Claim

(b) Each category of claim has its own set of claim and appeal requirements. The primary difference between the categories of claims is the timeframes within which claims will be determined.

(c) For the purpose of determining which claim and appeal procedures to follow, the claim type is determined initially. However, if the nature of the claim changes as it proceeds through the claim and appeal process, the claim can be re-characterized. For example, a claim may initially be an Urgent Pre-Service Claim. If the urgency subsides, it may be re-characterized as a Pre-Service Claim. Once the services are rendered and submitted to the Plan for payment, it becomes a Post-Service Claim.

8.4 Authorized Representative. For the purpose of this Plan's claims and appeal procedures, an Authorized Representative may act on a Claimant's behalf with respect to any aspect of a claim or appeal.

For Pre-Service Claims, Urgent Pre-Service Claims, and Concurrent Care Claims, the Plan will recognize a Healthcare Provider with knowledge of the Claimant's medical condition (e.g., the treating Physician) as the Claimant's Authorized Representative for both claims and appeals unless the Claimant provides specific written direction otherwise.

For Post-Service Claims, an "Authorized Representative" form must be received by the Plan in order for a person to be recognized as a Claimant's Authorized Representative for both claims and appeals. Such forms are available by calling or writing the Claims Administrator's customer service department:

MMSI
5777 East Mayo Boulevard
Phoenix, AZ 85054

1-866-465-5148
TDD (for hearing impaired) 1-800-407-2442

Once an Authorized Representative is recognized, the Plan will direct all information, notification, etc. regarding the claim to the Authorized Representative, unless the Claimant provides specific written direction otherwise.

8.5 Information Regarding Prescription Drugs.

(a) In-Network Pharmacies.

(1) When a Member has a prescription from a Healthcare Provider for a Prescription Drug, the Member should take the prescription to an In-Network pharmacy and present the prescription and his/her Membership Card to the pharmacy. Generally, the In-Network pharmacy will fill the prescription and collect a Cost Sharing Amount from the Member. *This is not considered a claim for benefits under the Plan*.

(2) If the In-Network pharmacy determines the Prescription Drug requested is not a Covered Service under the Plan, or if the Member disputes the Cost Sharing Amount determined by the pharmacy, the Member may do one of the following:

a) Pay the amount determined by the pharmacy and request reimbursement from the Plan or dispute the Cost Sharing Amount by following the procedure described below for filing a Post-Service Claim. The Plan will then determine whether the Prescription Drug is a Covered Service and/or the appropriate Cost Sharing Amount; or

b) Contact the Claims Administrator's Pharmacy Department to request a Pre-Determination. The Plan requires additional information for certain Prescription Drugs to determine whether they are Covered Services under the Plan. The Prescription Drugs that require this additional information are listed in the *Outpatient Prescription Drugs* subsection of the *Schedule of Benefits* section. If a Member would prefer to submit the information before filling the prescription, he/she may do so by having his/her Healthcare Provider contact the Claims Administrator's Pharmacy Department to provide the information requested. The Claims Administrator's Pharmacy Department will notify the Member and the Member's Healthcare Provider in writing whether or not the Prescription Drug requested is a Covered Service. If the Prescription Drug requested is a Covered Service, the Member will pay the appropriate Cost Sharing Amount at the pharmacy when picking up the Prescription Drug.

A Pre-Determination must be in writing and submitted to the Claims Administrator's Pharmacy Department at:

City of Scottsdale Medical Plan

c/o MMSI
5777 East Mayo Boulevard
Phoenix, AZ 85054

Attn: Pharmacy Dept.

Fax: 1-800-632-9885

Please note: *A Pre-Determination is not required in order to obtain coverage for any Prescription Drug. The additional information required for certain Prescription Drugs might also be submitted after following the procedures described below for filing a Post-Service Claim fills the prescription.*

The Member will be reimbursed if the Prescription Drug is a Covered Service.

(b) Out-of-Network Pharmacies. This Plan does provide coverage for Prescription Drugs obtained at Out-of-Network pharmacies except.

(1) If a Member needs a Prescription Drug and an In-Network pharmacy is not available, the Member should take the prescription to an Out-of-Network pharmacy. Generally, the Out-of-Network pharmacy will fill the prescription and collect a Cost Sharing Amount from the Member. *This is not considered a claim for benefits under the Plan*.

(2) If the Out-of-Network pharmacy determines the Prescription Drug requested is not a Covered Service under the Plan, or if the Member disputes the Cost Sharing Amount determined by the pharmacy, the Member may do one of the following:

a) Pay the amount determined by the pharmacy and request reimbursement from the Plan or dispute the Cost Sharing Amount by following the procedure described below for filing a Post-Service Claim. The Plan will then determine whether the Prescription Drug is a Covered Service and/or the appropriate Cost Sharing Amount; or

b) Contact the Claims Administrator's Pharmacy Department to request a Pre-Determination. The Plan requires additional information for certain Prescription Drugs to determine whether they are Covered Services under the Plan. The Prescription Drugs that require this additional information are listed in the *Outpatient Prescription Drugs* subsection of the *Schedule of Benefits* section. If a Member would prefer to submit the information before filling the prescription, he/she may do so by having his/her Healthcare Provider contact the Claims Administrator's Pharmacy Department to provide the information requested. The Claims Administrator's Pharmacy Department will notify the Member and the Member's Healthcare Provider in writing whether or not the Prescription Drug requested is a Covered Service. If the Prescription Drug requested is a Covered Service, the Member will pay the appropriate Cost Sharing Amount at the pharmacy when picking up the Prescription Drug.

A Pre-Determination must be in writing and submitted to the Claims Administrator's Pharmacy Department at:

City of Scottsdale Medical Plan

c/o MMSI
5777 East Mayo Boulevard
Phoenix, AZ 85054

Attn: Pharmacy Dept.

Fax: 1-800-632-9885

8.6 How to File a Claim.

(a) Post-Service Claims. Healthcare Providers may submit Post-Service Claims on a Claimant's behalf. *If a Healthcare Provider submits a Post-Service Claim on a Claimant's behalf, the Healthcare Provider will not be considered an Authorized Representative and will not receive the notification described below in the case of an Adverse Benefit Determination.*

(1) A Post-Service Claim must be submitted electronically or be in writing and submitted to:

Medical Services Claims	**Prescription Drug Claims**
Arizona Foundation for Medical Care (AFMC) **P.O. Box 2909** **Phoenix, AZ 85062-2909** **Payor ID # 86062** **www.AZFMC.com**	**MMSI** **c/o MMSI** **4001 41st Street NW** **Rochester, MN 55901-8901** **Attn: Pharmacy Dept.**

(2) A Post-Service Claim for medical services or supplies should be filed on a universal billing form and must include the following information:

- the name of the Plan
- the identity of the Claimant, Including name, address, and date of birth
- the date(s) of service
- the name and credentials of the Healthcare Provider
- the place of service
- a specific diagnosis code [current International Classification of Disease, Clinical Modification (ICD, CM) format]
- a specific service code for which payment is requested [current Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) format]
- the amount of billed charges
- if a Claimant has already paid for the medical service or supply and is requesting reimbursement, he/she must also submit proof of payment

(3) A Post-Service Claim for Prescription Drugs must be filed on a Prescription Drug claim form (which is available from the Claims Administrator) and must include the following information:

- the name of the Plan
- the identity of the Claimant, Including name, address, and date of birth
- the date(s) of service

- the name and credentials of the Healthcare Provider
- the place of service [e.g., National Association of Boards of Pharmacy (NABP) number]
- a specific diagnosis
- a specific product code for which payment is requested [current National Drug Code (NDC) format]
- the amount of billed charges
- if a Claimant has already paid for the Prescription Drug and is requesting reimbursement, he/she must also submit proof of payment

(4) A Post-Service Claim must be filed within one (1) year following the date of service.

(b) Pre-Service Claims (Including Urgent Pre-Service Claims). Typically, a Pre-Service Claim is made on the Claimant's behalf by the treating Physician as an Authorized Representative. However, it is the Claimant's responsibility to ensure that a Pre-Service claim has been filed. The Claimant can accomplish this by having his/her Healthcare Provider contact the Claims Administrator to file a Pre-Service Claim on behalf of the Claimant.

(5) A Pre-Service Claim must be submitted to:

MMSI
5777 East Mayo Boulevard
Phoenix, AZ 85054

Attn: Health Services Dept.

Fax: 1-800-632-9885
Urgent Pre-Service Claims and inpatient admissions where the underlying services do not require Prior Authorization may be submitted orally at the following phone numbers:

Providers: 1-888-894-4010

Members: 1-866-465-5148

(6) A Pre-Service Claim must include the following information:

- the name of the Plan
- the identity of the Claimant, Including name, address, and date of birth
- the proposed date(s) of service
- the name and credentials of the Healthcare Provider
- an order or request from the Healthcare Provider for the requested service
- the proposed place of service

- a specific diagnosis
- a specific proposed service code for which approval or payment is requested [current Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) format]
- clinical information for the Plan to make a Medical Necessity determination

(7) Incorrectly Filed Claim. Failure to submit a claim to the proper place and/or in writing, if required, may result in the claim being treated as an incorrectly filed claim. If a Pre-Service Claim has been filed incorrectly, the Plan will notify the Claimant as soon as possible but no later than the timeframes stated below:

a) Pre-Service Claims (not including Urgent Pre-Service Claims). No later than 5 days following receipt of the incorrectly filed claim.

b) Urgent Pre-Service Claims. No later than 24 hours following receipt of the incorrectly filed claim.

(c) Concurrent Care Claims. Where an extension is requested for benefits beyond the initially approved benefit, a Claimant should follow the instructions for how to file a Pre-Service Claim.

8.7 **Timeframes for Claim Decisions**. A Claimant may voluntarily agree to extend the timeframes specified below for the Plan to make a decision.

(a) Timeframes. The following timeframes apply unless the claim is incomplete, as described below.

(1) Post-Service Claims. The Plan will determine the claim within 30 days of receipt of the claim.

a) If the Plan is not able to determine the claim within this time period due to matters beyond its control, the Plan may take an additional period of up to 15 days to determine the claim. If this additional time will be needed, the Plan will notify the Claimant in writing prior to the expiration of the initial 30-day time period for determining the claim.

(2) Pre-Service Claims. The Plan will determine the claim within 15 days of receipt of the claim.

a) If the Plan is not able to determine the claim within this time period due to matters beyond its control, the Plan may take an additional period of up to 15 days to determine the claim. If this additional time will be needed, the Plan will notify the Claimant in writing prior to the expiration of the initial 15-day time period for determining the claim.

(3) Urgent Pre-Service Claims. The Plan will determine the claim as soon as possible but no later than 72 hours after receipt of the claim.

(4) Concurrent Care Claims.

a) For a reduction or termination of coverage for a previously approved benefit, the Plan will determine the claim sufficiently in advance to allow the Claimant to appeal and obtain a determination on review before coverage for the previously approved benefit is reduced or terminated.

b) Where an extension is requested by the Claimant for coverage beyond the initially approved benefit,

1) If the request meets the definition of an Urgent Pre-Service Claim and is filed at least 24 hours prior to the end of the treatment, the Plan will determine the claim within 24 hours.

2) If the request meets the definition of an Urgent Pre-Service Claim and is filed less than 24 hours prior to the end of the treatment, the Plan will determine the claim within 72 hours.

3) If the request does not meet the definition of an Urgent Pre-Service Claim, the Plan will determine the claim within 15 days.

(a) If the Plan is not able to determine the claim within this time period due to matters beyond its control, the Plan may take an additional period of up to 15 days to determine the claim. If this additional time will be needed, the Plan will notify the Claimant in writing prior to the expiration of the initial time period for determining the claim.

(b) Incomplete Claims.

(1) Post-Service Claims and Pre-Service Claims (not including Urgent Pre-Service Claims). Incomplete claims can be addressed through the extension of time described above. If the reason for the extension is the failure to provide necessary information and the Claimant is appropriately notified, the Plan's period of time to make a decision is suspended from the date upon which notification of the missing necessary information is sent until the date upon which the Claimant responds or should have responded.

The notification will include a timeframe of at least 45 days in which the necessary information must be provided. Once the necessary information has been provided, the Plan will decide the claim within the extension described above. If the requested information is not provided within the time specified, the claim may be denied.

(2) Urgent Pre-Service Claims. The Plan will notify the Claimant of an incomplete claim as soon as possible, but no later than 24 hours following receipt of the incomplete claim. The notification will describe the information necessary to complete the claim and specify the timeframe of at least 48 hours within which the claim must be complete.

Notification may be made orally to the Claimant or the Healthcare Provider, unless the Claimant requests written notice.

The Plan will make a claim determination as soon as possible but not later than

the earlier of (1) 48 hours after receipt of the specified information, or (2) the end of the period of time provided to submit the specified information.

8.8 Notification of Claim Decisions.

(a) When the Plan Will Provide Notification of a Claim Determination.

(1) Post-Service Claims and Concurrent Care Claims. Notification will be provided only if the decision is an Adverse Benefit Determination.

(2) Pre-Service Claims (Including Urgent Pre-Service Claims). Notification will be provided for all claim decisions.

(b) Content of Notification for All Claims.

(1) Adverse Benefit Determination. Notice of an Adverse Benefit Determination will be provided in written or electronic form. For Urgent Pre-Service Claims, notification will be provided orally to the Claimant within the timeframe described above and written or electronic notification will be furnished not later than 3 days after the oral notification.

The notification will include the following:

- the specific reason(s) for the determination;
- reference to the specific Plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to complete the claim and an explanation of why such information is necessary;
- a description of the Plan procedures and time limits for appeal of the Adverse Benefit Determination;
- disclosure of any internal rule, guideline, protocol or similar criterion relied on in making the Adverse Benefit Determination or a statement that such information was relied upon in making the Adverse Benefit Determination and will be provided free of charge upon request; and
- if the decision involves scientific or clinical judgment, an explanation of the scientific or clinical judgment applying the terms of the Plan to the Claimant's medical circumstances or a statement that such explanation will be provided free of charge upon request.

(2) Not Adverse Decision. For Pre-Service Claim and Urgent Pre-Service Claim determinations that are not adverse, notice that the request for Prior Authorization has been approved will be provided.

8.9 Complaints. If a Claimant has a complaint or dispute with this Plan, the Claimant may contact the Claims Administrator's customer service department by calling the number listed below in an attempt to resolve the complaint in an informal manner, rather than following the appeal procedures described below. If a complaint is submitted, the Claims Administrator will try to resolve the complaint through informal discussions within ten (10) days. If the complaint cannot

be resolved to the Claimant's satisfaction, the Claimant may submit a written appeal by following the appeal procedures described below.

1-866-465-5148
TDD (for hearing impaired) 1-800-407-2442

8.10 **Appeals Process**. The following will apply to all types and levels of appeal:

(a) Submission and Consideration of Comments. The Claimant will have the opportunity to submit documents, written comments, or other information in support of the appeal. The review of the Adverse Benefit Determination will take into account all information, whether or not presented or available for the initial determination. No deference will be given to the prior determination.

(b) Decision. A person will make the review different from the person who made the prior determination and such person will not be a subordinate of the prior decision maker.

(c) Consultation with Independent Medical Expert. In the case of a claim denied on the grounds of a medical judgment, a Healthcare Provider with appropriate training and experience will be consulted. The Healthcare Provider who is consulted on appeal will not be the individual who was consulted, if any, during the prior determination or a subordinate of that individual.

8.11 **Filing a First Level Appeal**. If there is an Adverse Benefit Determination or a denial of a Pre-Determination request, the Claimant may request a review by the Claims Administrator by filing a first level appeal.

(a) A first level appeal request must be in writing and submitted to:

MMSI
5777 East Mayo Boulevard
Phoenix, AZ 85054
Attn: Claims Review Unit

Special rule for expedited review of Urgent Pre-Service Claims: A Claimant may request an expedited review orally or in writing and all necessary information (Including the Plan's benefit determination on review) will be transmitted by telephone, facsimile, or other available expeditious method.

(b) A first level appeal must include the following information:

- the name of the Plan
- the identity of the Claimant, Including the Claimant's name, address, and date of birth
- information regarding the claim or Pre-Determination request the Claimant is appealing, such as:
    - for Post-Service Claims, a copy of the Explanation of Benefits or the claim number listed on the Explanation of Benefits
    - for other types of claims, a copy of the Adverse Benefit Determination notice

the Claimant received or other information to identify the claim

- for Pre-Determination requests, a copy of the denial letter

- a statement that the Claimant is requesting an appeal
- an explanation of why the Claimant is requesting an appeal, Including the particular aspect of the Adverse Benefit Determination or denial of a Pre-Determination request the Claimant is disputing
- supporting documentation

(c) A first level appeal of an Adverse Benefit Determination must be submitted to the Plan within 180 days following receipt of a notification of an Adverse Benefit Determination of a claim. *If a first level appeal is not requested within these 180 days, the Claimant loses the right to appeal.*

(d) A first level appeal of a denial of a Pre-Determination request must be submitted to the Plan within 60 days following receipt of a denial of a Pre-Determination request. *If a first level appeal is not requested within these 60 days, the Claimant loses the right to appeal.*

8.12 **Timeframes for First Level Appeals**. A Claimant may voluntarily agree to extend the timeframes specified below for the Plan to make a decision.

(a) Post-Service Claims. The Plan will make a determination no later than 30 days from the date the first level appeal was received.

(b) Pre-Service Claims. The Plan will make a determination no later than 15 days from the date the first level appeal was received.

(c) Urgent Pre-Service Claims. The Plan will make a determination no later than 36 hours from the date the first level appeal was received.

(d) Concurrent Care Claims.

(1) For a reduction or termination of coverage for a previously approved benefit, the Plan will make a determination sufficiently in advance to allow the Claimant to file a second level appeal and obtain a determination before the benefit is reduced or terminated.

(2) Where an extension is requested by the Claimant for coverage beyond the initially approved benefit:

a) If the request meets the definition of an Urgent Pre-Service Claim, the Plan will make a determination no later than 36 hours from the date the first level appeal was received.

b) If the request does not meet the definition of an Urgent Pre-Service Claim, the Plan will make a determination no later than 15 days from the date the first level appeal was received.

(e) Pre-Determination Requests. The Plan will make a determination no later than 60 days from the date the first level appeal was received.

(1) If the Plan is not able to determine the appeal within this time period, the Plan may take an additional period of up to 30 days to determine the appeal. If this additional time will be needed, the Plan will notify the Claimant prior to the expiration of the initial 60-day time period for determining the appeal.

8.13 Notification of Appeal Decisions.

(a) When Notice Will Be Provided. For appeals, written or electronic notification of the Plan's determination will be provided to the Claimant whether or not the decision is an Adverse Benefit Determination.

(b) Content of Notification.

(1) Adverse Benefit Determination. The notification will include the following:

- the specific reason(s) for the Adverse Benefit Determination;
- reference to the specific Plan provision(s) on which the determination is based;
- a statement indicating entitlement to receive, upon request, and free of charge, reasonable access to or copies of all documents, records and other information relevant to the Claimant's claim for benefits; and
- a statement regarding additional levels of appeal (if any);
- disclosure of any internal rule, guideline, protocol or similar criterion relied on in making the Adverse Benefit Determination (or a statement that such information will be provided free of charge upon request);
- if the decision involves scientific or clinical judgment, an explanation of the scientific or clinical judgment applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(2) Denial of Pre-Determination. The notification will include the specific reason(s) for the denial.

(3) Not Adverse Decision. Notice will be provided that informs the Claimant the decision has been reversed, and the claim has been approved.

8.14 Filing a Second Level Appeal For a level two appeal, the covered person must make his/her request to the City of Scottsdale Benefits Coordinating Committee in writing. The request must be filed within 60 days of the date of receipt of the level one notice of adverse benefit determination. The request must provide additional information and contain a copy of the reviewed denial letter and be filed by mail or hand delivered to:

City of Scottsdale
Benefits Coordinating Committee
Human Resources
7575 E. Main St.
Scottsdale, AZ 85251

It is the duty of the covered person to provide copies of the denial letter, all supporting bills and medical provider letters relative to medical condition and treatment stating why the claim should be paid.

The covered person does not need to attend the meeting of the City of Scottsdale Benefits Coordinating Committee. Should the covered person request to attend; they must notify the Benefits Coordinating Committee in writing indicating who would attend. Only the covered person and/or one representative may attend. The Benefits Coordinating Committee has the right to impose reasonable time limits on any presentation by the covered person or their representative.

Requests for appeal, which do not comply with this procedure and time limitation, will not be considered. The decision of the Benefits Coordinating Committee shall be the final decision of the City of Scottsdale.

Unless there are special circumstances, the appeals process outlined above must be completed prior to initiating legal action regarding a claim. If a Claimant intends to initiate legal action, he or she must do so within (2) years after receipt of a notification of Adverse Benefit Determination at the second level of appeal. If, due to special circumstances the Claimant was not required to complete the appeals process outlined above, legal action must be brought within two (2) years of the date the Claimant's claim for benefits was submitted to the Plan. Claimants may not bring legal action after the expiration of the two-year period.

8.15 **Plan Interpretation**. The Plan will be administered in accordance with its terms. The Employer, Claims Administrator and/or any other fiduciary acting as a fiduciary with respect to the Plan, to the extent that such individual or entity is acting in its fiduciary capacity, shall have the complete and final authority, responsibility, and control, in its sole discretion, to manage, administer and operate the Plan, to make factual findings, to construe the terms of the Plan, and to determine all questions arising in connection with the administration, interpretation, and application of the Plan, Including the eligibility and coverage of individuals and the authorization or denial of payment or reimbursement of benefits. All determinations and decisions will be binding on the Plan, Members, Claimants, and all interested parties.

8.16 **Questions Regarding Claims and Appeals Procedures.** If a Claimant has any questions regarding these procedures, the Claimant should contact the Claims Administrator's Customer Service Department at the number listed in the *Introduction* section.

SECTION IX

COORDINATION OF BENEFITS

9.1 Applicability.

(a) This coordination of benefits (COB) provision applies to *this plan* when an employee or the employee's covered dependent has healthcare coverage under more than one *plan*. "*Plan"* and "*this plan*" are defined below and have different meanings in this Coordination of Benefits Section (Section IX) than in the other Sections of this Plan**.** The words having special meanings for purposes of this Section only are typed in *italics*.

(b) If this coordination of benefits provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of *this plan* are determined before or after those of another *plan*. The benefits of *this plan*:

(1) shall not be reduced when, under the order of benefit determination rules, *this plan* determines its benefits before another *plan*; but

(2) may be reduced when, under the order of benefits determination rules, another *plan* determines its benefits first. The above reduction is described in Section 9.4.

9.2 Definitions.

(a) *"Plan"* is any of these which provides benefits or services for, or because of, medical or dental care or treatment:

(1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

(2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Arizona Health Care Cost Containment System (AHCCCS) or Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

Each contract or other arrangement for coverage under (a) or (b) is a separate *plan*. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate *plan*.

(b) "*This Plan*" is the part of the Plan that provides benefits for healthcare expenses.

(c) "*Primary Plan/Secondary Plan*": The order of benefit determination rules state whether *this plan* is a *primary plan* or *secondary plan* as to another *plan* covering the person.

When *this plan* is a *primary plan*, its benefits are determined before those of the other *plan* and without considering the other *plan's* benefits.

When *this plan* is a *secondary plan*, its benefits are determined after those of the other *plan* and may be reduced because of the other *plan's* benefits.

When there are more than two (2) *plans* covering the person, *this plan* may be a *primary plan* as to one (1) or more other *plans* and may be a *secondary plan* as to a different *plan* or *plans*.

(d) "*Allowable Expense*" means a necessary, reasonable, and customary item of expense for healthcare when the item of expense is covered at least in part by one (1) or more *plans* covering the person for whom the claim is made or service is provided.

When a *plan* provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an *allowable expense* and a benefit paid.

(e) "*Claim Determination Period*" means a Coverage Year. However, it does not include any part of a year during which a person has no coverage under *this plan*, or any part of a year before the date this COB provision or similar provision takes effect.

9.3 Order of Benefit Determination Rules.

(a) **General.** When there is a basis for a claim under *this plan* and another *plan*, *this plan* is a *secondary plan* which has its benefits determined after those of the other *plan*, unless:

(1) The other *plan* has rules coordinating its benefits with those of *this plan*; and

(2) Both those rules and *this plan's* rules in section 9.3(b) below, require that *this plan's* benefits be determined before those of the other *plan*.

(b) **Rules**. *This plan* determines its order of benefits using the first of the following rules which applies:

(1) **Nondependent/Dependent**. The benefits of the *plan* which covers the person as an employee, member, or subscriber (that is, other than as a dependent) are determined before those of the *plan* that covers the person as a dependent.

(2) **Dependent Child/Parents Not Separated Or Divorced**. Except as stated in Section 9.3(b)(3) below, when *this plan* and another *plan* covers the same child as a dependent of different persons, called "parents":

a) The benefits of the *plan* of the parent whose birthday falls earlier in the year are determined before those of the *plan* of the parent whose birthday falls later in that year; but

b) If both parents have the same birthday, the benefits of the *plan* which covered one (1) parent longer are determined before those of the *plan* that covered the other parent for a shorter period of time.

However, if the other *plan* does not have the rule described in (i) above, but instead has a rule based on the gender of the parent, and if, as a result, the *plans* do not agree on the order of the benefits, the rule in the other *plan* will determine the order of benefits.

(3) **Dependent Child/Parents Separated Or Divorced.** If two (2) or more *plans* cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

a) First, the *plan* of the parent with custody of the child;

b) Then, the *plan* of the spouse of the parent with custody of the child; and

c) Finally, the *plan* of the parent not having custody of the child.

however, if the specific terms of a court decree state that one (1) of the parents is responsible for the healthcare expense of the child, and the entity obligated to pay or provide the benefits of the *plan* of that parent has actual knowledge of those terms, the benefits of that *plan* are determined first. The *plan* of the other parent shall be the *secondary plan*. This paragraph does not apply with respect to any *claim determination period* or *plan* year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(4) **Joint Custody**. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one (1) of the parents is responsible for the healthcare expenses of the child, the *plans* covering follow the order of benefit determination rules outlined in section 9.3(b)(2).

(5) **Active/Inactive Employee**. The benefits of a *plan* which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a *plan* which covers that person as a laid off or retired employee (or as that employee's dependent). If the other *plan* does not have this rule, and if, as a result, the *plans* do not agree on the order of benefits, this rule 9.3(b)(5) is ignored.

(6) **Longer/Shorter Length Of Coverage**. If none of the above rules determines the order of benefits, the benefits of the *plan* which covered an employee, member, or subscriber longer are determined before those of the *plan* which covered that person for the shorter term.

9.4 Effect on the Benefits of *This Plan*.

(a) **When This Section Applies**. This Section 9.4 applies when, in accordance with Section 9.3, *this plan* is a *secondary plan* as to one (1) or more other *plans*. In that event, the benefits of *this plan* may be reduced under this Section. Such other *plan* or *plans* are referred to as "*the other plans*" in Section 9.4(b) below.

(b) **Reduction In *This Plan's* Benefits.** The benefits of *this plan* will be reduced when the sum of:

(1) The benefits that would be payable for the *allowable expense* under *this plan* in absence of this COB provision; and

(2) The benefits that would be payable for the *allowable expenses* under *the other plans*, in the absence of provisions with a purpose like that of this COB provision, whether or not the claim is made, exceeds those *allowable expenses* in a *claim determination period*. In that case, the benefits of *this plan* will be reduced so that they and the benefits payable under *the other plans* do not total more than those a*llowable expenses*.

When the benefits of *this plan* are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of *this plan*.

9.5 Right to Receive and Release Needed Information.

Certain facts are needed to apply these COB rules. The Plan has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The Plan need not tell, or get the consent of, any person to do this. Unless applicable federal or state law prevents disclosure of the information without the consent of the Member or the Member's representative, each person claiming benefits under *this plan* must give the Plan any facts it needs to pay the claim.

9.6 Facility of Payment.

A payment made under another *plan* may include an amount that should have been paid under *this plan*. If it does, the Plan may pay such amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under *this plan*. The Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

9.7 Subrogation.

If you or a covered family member receives benefits from this plan as the result of an illness or injury caused by another person, the Plan has the right to be reimbursed for those benefits from any settlement or payment you receive from the person who caused the illness or injury. This means the Plan may recover costs from all sources (including insurance coverage) potentially responsible for making any payment to you or your covered dependent as a result of an injury or illness, including:

- Uninsured motorist coverage;
- Underinsured motorist coverage;
- Personal umbrella coverage;
- Med-pay coverage;
- Workers' Compensation coverage;
- No-fault automobile coverage; or;
- Any first party insurance coverage.

If there is any question about the meaning or intent of this plan provision or any of its terms, the Plan will have the sole authority and discretion to resolve all disputes as to how this provision will be interpreted.

9.8 Workers' Compensation Injury and Illness.

The Plan may recover the cost of services provided to treat a Member for work-related injury or illness from the Member's worker compensation insurer or any other responsible party, except when prohibited by law.

9.9 Injuries Covered Under Med Pay Insurance.

If a Member receives medical care as a result of a motor vehicle accident, and the Member's medical expenses are covered in full or part by a medical payments provision under a motor

vehicle insurance policy owned by the Member or another family member (hereinafter called "Med Pay Insurance"), the rules of this Section 9.9 shall apply. In such instances, the Med Pay Insurance shall pay first, and the Plan shall pay only in the event the amount of Med Pay Insurance is insufficient to pay for the Member's medical expenses. The Plan reserves the right to require proof that the Med Pay Insurance carrier has paid the full amount required under its policy prior to making any payments under this Plan. If there is Med Pay Insurance in effect, but the Member waives or fails to assert his or her rights to such coverage, the Plan shall not be required to pay for medical expenses incurred or services and benefits provided that would have been covered under the Med Pay Insurance. Payment for such medical expenses, services and benefits shall be the responsibility of the Member. Pursuant to Section 9.7, the Plan may recover from the Med Pay Insurance carrier or from the Member, the cost of medical expenses incurred and services and benefits provided, if incurred or provided in excess of the Plan's obligations hereunder. The Member shall cooperate with and assist the Plan in recovering excess payments.

SECTION X

GENERAL PROVISIONS

10.1 **Applicable Law**. This Plan is intended to be construed, and all rights and duties hereunder are to be governed, in accordance with the laws of the State of Arizona, except to the extent the laws of the United States of America preempt such laws.

10.2 **Conformity with Governing Law**. If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

10.3 **Section Titles**. Section titles are for convenience only and are not to be considered in interpreting the Plan.

10.4 **No Guarantee of Employment**. Participation in the Plan will not be construed as giving a Member any right to continue in the employ of the Employer. Any Employee will remain subject to discharge by the Employer to the same extent had this Plan not been adopted.

10.5 **Plan Provisions Binding**. The provisions of the Plan will be binding upon all Members and their respective heirs and legal representatives, upon the Employer, its successors and assigns, and upon the Employer, Claims Administrator and any other provider of services to the Plan.

10.6 **Construction of Terms**. Words of gender will include persons and entities of any gender. The plural will include the singular, and the singular will include the plural.

10.7 **Non-Discrimination Policy**.

(a.) This Plan will not discriminate against any Member based on race, color, religion, national origin, disability, gender, sexual preference, or age. The Plan will not establish rules for eligibility based on health status, medical condition, claims experience, receipt of healthcare, medical history, evidence of insurability, genetic information, or disability.

(b.) Any portion of the Plan subject to Section 105(h) of the Code shall not discriminate in favor of highly paid Employees as to eligibility to participate or benefits.

10.8 **Privacy of Protected Health Information**

1 Definitions. The terms used in this *Privacy of Protected Health Information* attachment shall have the definitions ascribed in HIPAA and its implementing regulations.

2. Employer's (Plan Sponsor's) Certification of Compliance. Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose Members' protected health information to the Employer (plan sponsor) unless the Employer (plan sponsor) certifies that the Plan documents have been amended to incorporate this *Privacy*

of Protected Health Information attachment and agrees to abide by this *Privacy of Protected Health Information* attachment.

3. Purpose of Disclosure to Employer (Plan Sponsor).

   (a) The Plan and any health insurance issuer or business associate servicing the Plan will disclose Members' protected health information to the Employer (plan sponsor) only to permit the Employer (plan sponsor) to carry out plan administration functions for the Plan not inconsistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. Parts 160-64). Any disclosure to and use by the Employer (plan sponsor) of Members' protected health information will be subject to and consistent with the provisions of paragraphs 3 and 4 of this *Privacy of Protected Health Information* attachment.

   (b) Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose Members' protected health information to the Employer (plan sponsor) unless the disclosures are explained in the Notice of Privacy Practices distributed to Subscribers.

   (c) Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose Members' protected health information to the Employer (plan sponsor) for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer (plan sponsor).

4. Restrictions on Employer's (Plan Sponsor's) Use and Disclosure of Protected Health Information.

   (d) The Employer (plan sponsor) will neither use nor further disclose Members' protected health information, except as permitted or required by the Plan documents, as amended, or required by law.

   (e) The Employer (plan sponsor) will ensure that any agent, including any subcontractor, to whom it provides Members' protected health information agrees to the restrictions and conditions of the Plan documents, including this *Privacy of Protected Health Information* attachment, with respect to Members' protected health information.

   (f) The Employer (plan sponsor) will not use or disclose Members' protected health information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer (plan sponsor).

   (g) The Employer (plan sponsor) will report to the Plan any use or disclosure of Members' protected health information that is inconsistent with the uses and disclosures allowed under this *Privacy of Protected Health Information* attachment promptly upon learning of such inconsistent use or disclosure.

(h) The Employer (plan sponsor) will make protected health information available to the Member who is the subject of the information in accordance with 45 Code of Federal Regulations § 164.524.

(i) The Employer (plan sponsor) will make Members' protected health information available for amendment, and will on notice amend Members' protected health information, in accordance with 45 Code of Federal Regulations § 164.526.

(j) The Employer (plan sponsor) will track disclosures it may make of Members' protected health information so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 Code of Federal Regulations § 164.528.

(k) The Employer (plan sponsor) will make its internal practices, books, and records, relating to its use and disclosure of Members' protected health information, to the Plan and to the U.S. Department of Health and Human Services to determine compliance with 45 Code of Federal Regulations Parts 160-64.

(l) The Employer (plan sponsor) will, if feasible, return or destroy all Member protected health information, in whatever form or medium (including in any electronic medium under the Employer's (plan sponsor's) custody or control), received from the Plan, including all copies of and any data or compilations derived from and allowing identification of any Participant who is the subject of the protected health information, when the Members' protected health information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Member protected health information, the Employer (plan sponsor) will limit the use or disclosure of any Member protected health information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

5. Adequate Separation Between the Employer (Plan Sponsor) and the Plan.

(m) The following employees or classes of employees or other workforce members under the control of the Employer (plan sponsor) may be given access to Members' protected health information received from the Plan or a health insurance issuer or business associate servicing the Plan:

Sr. Benefits Analyst and staff of the City designated by the Sr. Benefits Analyst

(n) The employees, classes of employees or other workforce members identified above will have access to Members' protected health information only to perform the plan administration functions that the Employer (plan sponsor) provides for the Plan.

(o) The employees, classes of employees or other workforce members identified above will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Employer (plan sponsor), for any use or disclosure of Members' protected health information in breach or violation of or noncompliance with the provisions of this *Privacy of Protected Health Information* attachment. The Employer (plan sponsor) will promptly report such breach, violation or noncompliance to the Plan, as required by paragraph 3(d) of

this *Privacy of Protected Health Information* attachment, and will cooperate with the Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any Participant, the privacy of whose protected health information may have been compromised by the breach, violation or noncompliance.

Effective April 21, 2005 in compliance with **HIPAA Security** regulations, the Plan Sponsor will:

1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan,
2. Ensure that the adequate separation discussed in D above, specific to electronic PHI, is supported by reasonable and appropriate security measures,
3. Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and
4. Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

SECTION XI

PLAN ADMINISTRATION

11.1 **Powers and Duties of Employer**. The Employer will have the powers and duties of the general administration of the Plan Including the following:

(a) The discretion to determine all questions relating to the eligibility of individuals to participate or remain a Member in the Plan and to receive benefits under the Plan. In carrying out their respective responsibilities under the Plan, the Plan Administrator or its delegate, other Plan fiduciaries, and the insurers or administrators of each Program of the Plan, have full discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority would be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

(b) To require any person to furnish such reasonable information as the Employer may request for the proper administration of the Plan as a condition of eligibility to participate as a Member under the Plan and to receive any benefits under the Plan.

(c) To delegate to other persons authority to carry out any duty or power which would otherwise be a responsibility of the Employer under the terms of the Plan or applicable law.

(d) To maintain, or to delegate to others the duty of maintaining, all necessary records for the administration of the Plan.

(e) To interpret the provisions of the Plan and to make and publish such rules and procedures for regulation of the Plan and to prescribe such forms as the Employer will deem necessary.

11.2 **Claims Administrator**. The Claims Administrator is a third party retained by the Employer. The Claims Administrator's responsibilities typically consist of initially determining the validity of claims and administering benefit payments under this Plan. The actual responsibilities of the Claims Administrator are described in the contract between the Employer and the Claims Administrator.

11.3 **Records**. The Employer, the Claims Administrator and others to whom the Employer has delegated duties and responsibilities under the Plan shall keep accurate and detailed records of any matters pertaining to administration of the Plan in compliance with applicable law.

11.4 **Release of Medical Information**. The Employer and Claims Administrator are entitled to receive information reasonably necessary to administer this Plan, subject to all applicable confidentiality requirements as defined in this Plan and as required by law, from any Healthcare Provider of services to a Member. By accepting coverage under this Plan, Members agree to sign the necessary authorization directing any Healthcare Provider that has attended or treated

them, to release to the Employer and Claims Administrator upon request, any and all information, records or copies of records relating to attendance, examination or treatment rendered to Member. If the Member fails to sign the necessary authorization or otherwise inhibits the Employer and/or Claims Administrator from getting necessary information to pay claims, the Plan has no obligation to pay claims.

11.5 **Payment to Healthcare Providers and Assignment of Benefits.** When a Member receives Covered Services from an In-Network Healthcare Provider, the Plan pays the In-Network Healthcare Provider. When a Member receives Covered Services from an Out-of-Network Healthcare Provider, the Plan does not pay the Out-of-Network Healthcare Provider, unless the Member provides the Plan with satisfactory proof that the Member has complied with all of the requirements for coverage. A Member's right to receive benefits hereunder is personal to that Member and may not be assigned, or be subject to anticipation, garnishment, attachment, execution, or levy of any kind, or be liable for the debts or obligations of a Member, except for assignment of the right to receive benefits to a Healthcare Provider.

11.6 **Agent for Service of Legal Process**. **City of Scottsdale** shall be an agent for service of legal process with respect to the Plan.

SECTION XII

CONTRIBUTIONS

12.1 **Allocation of Plan Cost**. Prior to each Coverage Year, the Employer will determine the aggregate cost necessary to provide the benefits under the Plan.

12.2 **Subscriber Contributions**. For each Coverage Year, the Employer will determine the amount of Subscriber contributions, if any, that Subscribers or any subgroup of Subscribers will be required to pay for coverage under this Plan. The portion of the cost of coverage for which the Subscriber is responsible may be paid on a pre-tax basis (except for Domestic Partner coverage and certain dependent children of domestic partners) through a cafeteria plan of the Employer if the Employer makes such a plan available.

SECTION XIII

AMENDMENT AND TERMINATION

13.1 **Amendment**. The Employer reserves the right to amend or modify all or any portion of the coverage under this Plan at any time on a prospective basis, any such action being within its complete and sole discretion.

13.2 **Termination**. The Employer reserves the right to terminate all or any portion of the Plan at any time, any such action being within its complete and sole discretion.